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## Civil Commitment in New York City: An Analysis of Practice

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# Civil Commitment in New York City: An Analysis of Practice\*

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## I. Introduction

Laws exist in every state allowing for the involuntary mental hospitalization of persons believed to suffer from mental disorder.<sup>1</sup> These laws are grounded in the state's *parens patriae* power, to care for persons who are unable to care for themselves, and its police power, to protect the public safety and welfare.<sup>2</sup>

In most states prior to the 1960's, involuntary civil commitment was largely a medical phenomenon. Anyone a physician deemed to be in need of treatment might have been subject to commitment; court involvement, where provided for, typically was little more than an "administrative monitoring, often cursory, of a medically oriented process upon which jural apparatus ha[d] been grafted."<sup>3</sup> In the last twenty years, however, this

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1. In many jurisdictions, other than New York, involuntary outpatient treatment also is possible. See generally, *Practice Manual — State Laws Governing Civil Commitment*, 3 MENTAL DISABILITY L. REP. 205, 205-14 (1979).

2. See *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1207-28 (1974).

3. R. ROCK, M. JACOBSON & R. JANOPAUL, *HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL* 259 (1968).

medical approach to commitment decisionmaking has given way in most states to a more legalistic, due process approach. Pointing to the "massive curtailment of liberty"<sup>4</sup> that involuntary commitment entails, lawmakers throughout the country have tightened commitment standards and accorded prospective patients an array of procedural rights and protections.<sup>5</sup> Some observers contend that this "legalization" of the civil commitment process has gone too far: that in many areas of the country it has become unreasonably difficult to ensure that even seriously disordered persons receive the treatment they need.<sup>6</sup> Others suggest that, despite these changes in the law, civil commitment

4. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

5. See Zimmerman & Fitch, *Involuntary Civil Commitment: The Discerning Eye of the Law*, 5 STATE CT. J. Fall 1981, at 5. See, e.g., ALA. CODE §§ 22-52-1 to -10 (Supp. 1983); ARIZ. REV. STAT. ANN. §§ 36-501 to -520 (Supp. 1983-1984); CAL. WELF. & INST. CODE § 5150 (West 1984); CONN. GEN. STAT. ANN. §§ 17-176 to -183 (West Supp. 1984); GA. CODE ANN. §§ 37-3-1, -61, -62 (1982); HAWAII REV. STAT. §§ 334-59 to -60 (Supp. 1983); IDAHO CODE ANN. §§ 66-317 to -329 (Supp. 1984); ILL. REV. STAT. ch. 91½, § 1-119 (Supp. 1984-1985); IND. CODE ANN. § 16-14-9.1-1, -10 (Burns Supp. 1984); IOWA CODE ANN. § 229.11 (West Supp. 1984-1985); KAN. STAT. ANN. §§ 59-2908, -2909 (1983); KY. REV. STAT. ANN. §§ 202A.014 to .191 (1982); LA. REV. STAT. ANN. §§ 28:2, :54 (West Supp. 1984); ME. REV. STAT. ANN. tit. 34, §§ 2332-A, 2333 (Supp. 1983-1984); MD. ANN. CODE art. 59, §§ 12, 22 (1979); MASS. GEN. LAWS ANN. ch. 123, §§ 1, 12 (West Supp. 1984-1985); MICH. COMP. LAWS ANN. § 330.1401 (West Supp. 1984-1985); MINN. STAT. ANN. §§ 253A.02, .04 (West 1982); MONT. CODE ANN. §§ 53-21-102 to -129 (1981); NEB. REV. STAT. §§ 83-1009, 1020, 1037 (1981); NEV. REV. STAT. §§ 433.194, 433A.170, .200 (1979); N.H. REV. STAT. ANN. §§ 135-B: 19, :20 (Supp. 1978); N.J. STAT. ANN. §§ 30:4-23, -25, -26.3 (West 1981); N.M. STAT. ANN. § 43-1-3 to -10 (1984); N.Y. MENTAL HYG. LAW §§ 9.37-43 (McKinney 1978 & Supp. 1983-1984); N.C. GEN. STAT. § 122-58.2, -58.3 (1981 & Supp. 1983); N.D. CENT. CODE §§ 25-03.1, -02, -09 (Supp. 1983); OKLA. STAT. ANN. tit. 43A, §§ 3, 54.4 (West Supp. 1983-1984); ORE. REV. STAT. § 426.175 (1983); PA. STAT. ANN. tit. 50, §§ 7301-7303 (Purdon Supp. 1984-1985); S.D. CODIFIED LAWS ANN. § 27A-10-1 (Supp. 1981); TENN. CODE ANN. § 33-6-104 (Supp. 1984); UTAH CODE ANN. § 64-7-36 (Supp. 1983); VT. STAT. ANN. tit. 18, §§ 7101, 7504 (Supp. 1984); W. VA. CODE § 27-5-2 (Supp. 1984); WIS. STAT. ANN. §§ 51.01, .15, .20 (West Supp. 1983-1984); WYO. STAT. §§ 25-10-101 to -112 (1981).

6. See Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 497 (1976); Dickey, *Incompetency and the Nondangerous Mentally Ill Client*, 16 CRIM. L. BULL. 22 (1980). See generally, A. STONE, *MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION* 62 (1976); Hoffman, *Living with Your Rights Off*, 5 AM. ACAD. PSYCHIATRY & L. BULL. 68 (1977); Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIATRY 65 (1980). Although few recommend revoking any legal protections, many question the wisdom of further expansion. See, e.g., Weitzel, *Changing Law and Clinical Dilemmas*, 134 AM. J. PSYCHIATRY 293 (1977); Nedelsky & Schotten, *Civil Commitment and the Value of Liberty*, 46 SOC. RESEARCH 374 (1979).

practices have changed very little over the years and persons who threaten neither themselves nor others continue to be hospitalized as before.<sup>7</sup>

In the interest of assessing the degree to which civil commitment practices reflect civil commitment laws, and, moreover, to identify ways in which civil commitment systems might function more effectively, the Institute on Mental Disability and the Law of the National Center for State Courts embarked, in 1981, on a multi-year study of civil commitment practices and procedures throughout the country.<sup>8</sup> New York City was one of six cities in which empirical research was conducted.<sup>9</sup> This Article presents the findings of the research conducted in New York.<sup>10</sup>

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7. See Peters, Teply, Wunsch & Zimmerman, *Administrative Civil Commitment: The Ins and Outs of the Nebraska System*, 9 CREIGHTON L. REV. 266 (1975); Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. 629 (1977); Markell & Hiday, *Standards of Dangerousness: Impact of Civil Commitment* (unpublished manuscript) (available from Dr. Virginia Hiday, Sociology Department, North Carolina State University). The tension between protecting the mentally ill of New York and preserving their rights most recently appeared in *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983). In that case, the United States Court of Appeals for the Second Circuit decided that New York civil commitment procedures satisfied the due process requirements of the United States Constitution. *Id.* at 971.

8. The general study methods of the Involuntary Civil Commitment Project are described in the Appendix to this Article.

9. The results of the New York study are compiled in W. FITCH, B. MCGRAW, J. HENDRYX & T. MARVELL, *INVOLUNTARY CIVIL COMMITMENT IN THE FIRST JUDICIAL DEPARTMENT, NEW YORK CITY* (1982). For the results of the remaining studies, see W. FITCH, *INVOLUNTARY CIVIL COMMITMENT IN WINSTON-SALEM* (1982); I. KEILITZ & B. MCGRAW, *AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY* (1983); I. KEILITZ, *INVOLUNTARY CIVIL COMMITMENT IN COLUMBUS, OHIO* (1982) [hereinafter cited as I. KEILITZ, OHIO]; I. KEILITZ, W. FITCH & B. MCGRAW, *INVOLUNTARY CIVIL COMMITMENT IN LOS ANGELES COUNTY* (1982); J. ZIMMERMAN, *INVOLUNTARY CIVIL COMMITMENT IN CHICAGO* (1982) (These monographs are available at the National Center for State Courts in Williamsburg, Virginia.). See also, Keilitz, Fitch & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 SW. U.L. REV. 238 (1984); Keilitz & Roach, *A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio*, 13 CAP. U.L. REV. 175 (1983); Van Duizend & Zimmerman, *Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 DE PAUL L. REV. 225 (1984). This research provided the basis for the development of national-scope guidelines for civil commitment. See INSTITUTE ON MENTAL DISABILITY AND THE LAW, *PROVISIONAL SUBSTANTIVE AND PROCEDURAL GUIDELINES FOR INVOLUNTARY CIVIL COMMITMENT* (1982) [hereinafter cited as *PROVISIONAL GUIDELINES*]. The National Task Force Guidelines for Involuntary Civil Commitment is currently revising *Provisional Guidelines*.

10. The research in New York was conducted in late 1981 and mid-1983, and the findings reported in this Article are based on research from those years.

It consists of a descriptive analysis of the City's civil commitment system,<sup>11</sup> with suggestions for improvement. The descriptive information is drawn primarily from interviews with representatives of the legal and mental health communities in New York and observation of judicial hearings and other commitment proceedings.<sup>12</sup> The recommendations reflect the observations and opinions of the persons interviewed as well as those of the research staff and their advisors.<sup>13</sup>

## II. The Prehearing Process

The manner in which commitment cases are handled prior to hearings may have more bearing on the overall success of a commitment system than what happens at any other stage in the commitment process. Systems that provide for effective screening and diversion of inappropriate cases protect both the liberty interests of the respondent<sup>14</sup> and the fiscal interests of the state.

This section considers the events that occur in the involuntary commitment process of New York before a judicial hearing. Many cases are disposed of in this prehearing stage. Respondents in some cases are screened from hospitalization by the physician conducting the initial evaluation; other respondents

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11. The focus of this Article is on procedures for the civil commitment of mentally ill persons in New York. The Article is not intended to apply to the commitment of juveniles, the mentally retarded, the developmentally disabled, or persons charged with, convicted of, or acquitted by reason of insanity of a criminal offense.

12. Research staff interviewed judges, court clerks, attorneys, psychiatrists, psychologists, social workers, hospital administrative personnel, law enforcement officers, former patients, families of patients, and state agency representatives. Throughout this Article all sources are reported as generic categories of people, such as judges, attorneys, hospital staff, and the like in order to ensure the anonymity of the sources interviewed. For a description of the study methods used in conducting this research, see Appendix.

13. During the course of the study, the research staff was counseled by a board of advisors consisting of Paul Appelbaum, University of Pittsburgh; Paul Friedman, Ennis, Friedman, Bersoff, and Ewing; B. James George, Jr., New York Law School; Richard P. Lynch, American Bar Association; Floyd E. Propst, Fulton County (Georgia) Probate Court; Loren H. Roth, University of Pittsburgh; Joseph Schneider (chairperson), Cook County (Illinois) Circuit Court; David B. Wexler, University of Arizona; and Helen Wright, National Association for Mental Health.

14. The terms "respondent" and "patient" are used as synonyms throughout in this study. Technically, a "patient" is one who has been admitted for mental health treatment, with or without court involvement. A "respondent" is the subject of an involuntary commitment proceeding.

may be hospitalized for a brief period but are discharged before any legal process begins. Some become voluntary patients, obviating the need for any judicial involvement.

### A. *Initiating Mental Health Treatment*

The vast majority of involuntary admissions in New York City are initiated as emergency admissions.<sup>15</sup> The emergency admissions statute provides that a person may be involuntarily hospitalized for up to fifteen 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."<sup>16</sup>

Virtually all emergency admissions in the city are initiated by the police, who have statutory authority to take into custody anyone who appears to meet the emergency admissions criteria.<sup>17</sup> The police department's *Patrol Guide*<sup>18</sup> outlines the procedures to be followed when an officer believes a person meets these criteria. The *Patrol Guide*, however, prescribes no specific behavioral criteria to assist the officer in determining when a

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15. See N.Y. MENTAL HYG. LAW § 9.41 (McKinney 1978 & Supp. 1984-1985). Five additional procedures are authorized for initiating involuntary civil commitment, all but one of which are rarely if ever used in New York City. See *id.* § 9.43(a) (McKinney 1978) (court-ordered hospitalization based on verified statement that respondent is mentally ill and disorderly or dangerous); *Id.* § 9.43(b) (court-ordered hospitalization of criminal defendant found not guilty but apparently mentally ill and dangerous); *Id.* § 9.45 (McKinney 1978 & Supp. 1984-1985) (hospitalization by director of community services of person reported by specified individual to be mentally ill and dangerous); *Id.* § 9.37 (hospitalization by director of community services or designated physician of a person found, generally pursuant to personal examination to be mentally ill and dangerous.); *Id.* § 9.27 (hospitalization of person alleged to be mentally ill and in need of involuntary care and treatment based upon two-physician certification). The two-physician certification procedure is used in New York City. See *infra* notes 28-33 and accompanying text.

16. N.Y. MENTAL HYG. LAW § 9.39 (McKinney 1978). For statutory definition of "likelihood to result in serious harm," see *infra* note 107 and accompanying text. Hospitals may take emergency admissions if they maintain the appropriate staff and facilities and are approved by the Commissioner of the Department of Mental Hygiene. The Department's Regulations, N.Y. ADMIN. CODE tit. 14, § 15.9(e), lists the regional offices of the Office of Mental Health, from which current listings of approved facilities may be obtained. In the First Judicial Department, there are about 14 such facilities.

17. N.Y. MENTAL HYG. LAW § 9.41 (McKinney 1978 & Supp. 1983-1984). Peace officers also are authorized to initiate emergency detention. *Id.*

18. NEW YORK CITY POLICE DEPARTMENT, PATROL GUIDE 106-11 (as revised Aug. 1981) [hereinafter cited as PATROL GUIDE].

person is mentally ill and dangerous; individual police officers are expected to make such judgments based on their own experience.

It is the police department's policy not to become involved in potential commitment cases unless the prospective patient presents a threat of immediate, serious harm. The police generally will not take a person into custody solely on the basis of an allegation; rather, they will act only if an officer personally observes the aberrant behavior.

The screening provided by the police is regarded highly by observers in the city. Although some complain that the police miss many deserving cases by refusing to respond to all but the most serious incidents, the department's limited resources allow for little more. Furthermore, given that the city's hospitals admit only about fifty percent of all prospective patients brought in by the police,<sup>19</sup> relaxing the criteria for police transport may result in no significant increase in emergency admissions.

The *Patrol Guide* states that the officer taking custody may use only such physical force as is minimally required to restrain the person or to prevent serious physical injury.<sup>20</sup> Before taking the person into custody, the officer first must contain him and call the patrol supervisor and the Emergency Service Unit for assistance.<sup>21</sup> The patrol supervisor may cancel the request for assistance from the Emergency Service Unit, if it is not needed, and request the aid of other services, such as an interpreter, a hostage negotiating team, or a clergyman.<sup>22</sup> If available, an ambulance must be used to transport the person to the hospital.<sup>23</sup> A patrol car, however, may be used to expedite transportation in the face of a potentially explosive situation.<sup>24</sup> The police officer must accompany the prospective patient to the hospital; two officers are required if two or more persons are being trans-

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19. These estimates were provided by hospital admissions officers.

20. *PATROL GUIDE*, *supra* note 17, at 104-10, 106-11 ("physical force is used ONLY to the extent necessary to restrain the subject until delivered to a hospital or detention facility") (emphasis in original).

21. *Id.*

22. *Id.*

23. *Id.* at 106-11.

24. *Id.*



ported.<sup>25</sup> The officer or officers must remain at the hospital until the examination begins and must inform the examining physician of the events leading to the custody-taking.<sup>26</sup>

Many procedures set out in the *Patrol Guide* reportedly were conceived as time-saving devices. They reflect a deep concern about the limited resources available to the department to handle these cases. While the size of the city's police department has been substantially reduced in recent years<sup>27</sup> because of the city's fiscal difficulties, the volume of commitments has greatly increased.<sup>28</sup> Particularly in light of these constraints, the department's emergency admissions procedures are to be commended. Some measures can be taken, however, to make even better use of the department's limited resources. For example, requiring police officers to wait at the hospital while the prospective patient is being examined is highly inefficient. Although the examining physician should have access to whatever information the officer can provide, the officer could present this information in writing instead of waiting to present the information in person. Accordingly, a procedure should be developed to permit the police officer, who is transporting someone to a hospital pursuant to the emergency admissions procedure, to leave the person in the custody of the hospital pending the examination. Hospital staff should develop a standard set of questions designed to elicit from police officers information that generally would be helpful to the physician. The questions should be available to the police beforehand so that responses may be presented at the emergency room.

The "two-physician certification" procedure, commonly referred to as the "two P.C." commitment, is the standard procedure for non-emergency hospitalization in New York City and is routinely used by the hospital staff to extend the hospitalization of a person initially admitted under the emergency procedure.<sup>29</sup>

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25. *Id.*

26. *Id.*

27. Representatives of the department report that the number of officers has been reduced by one-third in the last five years.

28. According to police department statistics, the number of people transported to hospitals for examination increased from 1,084 in 1976 to 7,785 in 1980, almost doubling every year.

29. N.Y. MENTAL HYG. LAW § 9.39 (McKinney 1978).

Under this procedure, anyone alleged to be mentally ill and in need of care and treatment<sup>30</sup> may be involuntarily hospitalized upon the application of several statutorily designated individuals.<sup>31</sup> The application must be accompanied by two physician's certificates prepared on the basis of examinations conducted not more than ten days prior to the making of the application.<sup>32</sup>

Before each examining physician certifies a patient for involuntary admission to a hospital, the statute requires the physician to "consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization."<sup>33</sup> This provision requires only that each physician "consider" alternatives, but does not require a physician to take any particular action regarding actual alternative placement. Several attorneys interviewed suggested that this provision makes little difference in the admission decision because physicians generally fail to seriously consider alternatives. They said that the two-physician certification papers are used as a way of giving legal status to a clinical situation. That is, the consideration of alternatives amounts to a procedural and not substantive impediment to involuntary admission. These attorneys suggested that at retention hearings, which respondents may request to challenge their certification,<sup>34</sup> the examining physicians have become sophisticated enough to tailor answers to questions regarding alternatives to support the recommendation for hospitalization.

During hearings that the authors observed, the testimony of examining physicians tended to include general statements to the effect that no suitable alternatives existed, without mentioning any specific facilities or programs. The testimony focused on the severity of the particular patient's condition and the neces-

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30. See *infra* note 110 and accompanying text.

31. N.Y. MENTAL HYG. LAW § 9.27(b) (McKinney 1978 & Supp. 1983-1984). This list includes anyone residing with the respondent, a member of the respondent's immediate family, or the director of a hospital where the respondent resides. *Id.*

32. N.Y. MENTAL HYG. LAW § 9.27 (McKinney 1978). A third physician, on the hospital staff, must also examine the person and certify that he or she needs involuntary care. *Id.* § 9.27(e). An individual so admitted may be retained without court order for 60 days.

33. *Id.* § 9.27(d).

34. See *id.* § 9.31(a). The hospital director must apply for a court order to continue involuntary retention beyond 60 days of admission. *Id.* § 9.33(a).

sity for twenty-four hour, inpatient supervision. In rare instances, examining physicians testified generically about possible alternatives. For example, one physician testified that support services provided to the patient in her own home would be inappropriate. Another testified that a patient could not be released to his family because the family was not receptive. In all cases observed, the court ordered the maximum six-month retention.<sup>35</sup>

### B. Screening

Several stages of clinical assessment follow the initial police screening in emergency admission cases. In at least one city hospital, psychiatric nurses review the prospective patient and may refuse to admit him to the psychiatric unit if: (1) he has a serious medical problem, in which case he is transferred to a general hospital unit for treatment, where he remains until cleared medically, or (2) he does not evidence symptoms of mental illness sufficient to merit attention by the unit. After this initial screening, a physician examines the prospective patient to determine his suitability for admission.<sup>36</sup> Psychiatrists, often psychiatric residents, perform these examinations in the emergency room soon after the police present the respondent for admission.

If the respondent is found not to meet the criteria for commitment,<sup>37</sup> the hospital staff may refer him to a program of services in the community or may simply release him. Police officers may transport a respondent denied admission back to his community or, depending on the circumstances leading to the custody-taking, may take him to the police station to be charged with a crime.

Persons hospitalized under the emergency admissions procedure may not be retained in the hospital for more than forty-eight hours unless a second examination by a physician confirms the finding of mental illness and dangerousness.<sup>38</sup> There is some confusion whether this examination must be performed within forty-eight hours of the person's arrival at the hospital or within

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35. See N.Y. MENTAL HYG. LAW § 9.33(b) (McKinney 1978).

36. *Id.* § 9.39.

37. Reportedly, 50 to 60% of police referrals survive the hospital's strict application of criteria for emergency admission.

38. N.Y. MENTAL HYG. LAW § 9.39 (McKinney 1978).

forty-eight hours of his or her formal admission by the examining physician.<sup>39</sup> In any event, this system of screening protects patients against unwarranted involuntary hospitalization and spares society the cost of providing unnecessary care and treatment.

### C. *Notifying Respondents of Rights*

New York law requires that upon a respondent's admission to a hospital or his conversion from voluntary to involuntary status, the hospital director must immediately inform him in writing of his status, his rights under the law, and the availability of assistance from the Mental Health Information Service (MHIS).<sup>40</sup> In addition, notices of patient rights must be posted in conspicuous places throughout the hospital.

In New York City, respondents in commitment proceedings are informed verbally of their rights at several stages in the process. Although the police ordinarily do not inform respondents of their rights during the custody-taking unless a criminal charge is placed, examining physicians advise patients of their rights during the initial examination in the emergency room. After admission, MHIS staff are available to meet with patients and explain in more detail their rights under the law. MHIS staff meet with all who specifically request their services, but because of limited resources, cannot meet with everyone admitted involuntarily.

Although every respondent is advised of his rights at least once in the commitment process, the information provided may not always be understood. Many hospital personnel consider the notification of rights to be useless if the patient is too disoriented, anxious, or confused to comprehend the information. "Overwhelming" such patients with "confusing papers" and "verbal gibberish" may merely exacerbate an already strained situation, they contend. Indeed, if "confusing papers" and "verbal gibberish" are all that is used to communicate this advice, it should not be surprising that patients have no clear understand-

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39. Many interviewees believed hospitals more quickly release patients who request hearings.

40. N.Y. MENTAL HYG. LAW § 9.07 (McKinney 1978). See *infra* notes 68-71 and accompanying text for discussion of availability of community assistance.

ing of their legal rights. Given that hearings on the question of commitment are not mandatory, but rather are held only upon the respondent's request,<sup>41</sup> greater effort must be made to make patients aware of their rights. The physicians conducting the initial examination should take great care to use language the patient can understand and should question the patient concerning his understanding of what has been said. The MHIS should consider, as a matter of first priority, meeting personally with each patient soon after his or her admission.

#### D. *Alternatives to Involuntary Admission*

Persons subject to commitment proceedings, and other mentally ill persons in New York, may be admitted for inpatient psychiatric treatment as informal patients, voluntary patients, or involuntary patients. A hospital director may *informally* admit a person requesting treatment without requiring a formal application. An informal patient may leave at any time.<sup>42</sup> *Voluntary* admissions require that the prospective patient apply for admission in writing.<sup>43</sup> Ordinarily, voluntary patients must be released promptly upon their request. The hospital director may retain a voluntary patient for up to seventy-two hours, however, if there are "reasonable grounds for belief that the patient may be in need of involuntary care and treatment."<sup>44</sup> At the end of seventy-two hours, the director must either release the patient or apply for involuntary commitment of the patient.<sup>45</sup>

Voluntary and informal admissions are preferred to involuntary admissions.<sup>46</sup> The apparent legislative intent that invol-

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41. See *infra* notes 105-108 and accompanying text.

42. N.Y. MENTAL HYG. LAW § 9.15 (McKinney 1978).

43. *Id.* § 9.13. A hospital director may receive as a patient "any suitable person in need of care and treatment, who voluntarily makes written application therefore." *Id.* The applicant must have a "mental illness for which in-patient care and treatment in a hospital is appropriate." *Id.* § 9.01. Further, the applicant must be told and be able to understand that he is applying to a mental institution, and that he is subject to provisions governing release and conversion to involuntary status. *Id.* § 9.17(a). Finally, the Mental Health Information Service must conduct a yearly review of the patient's status. *Id.* § 9.25(a).

44. N.Y. ADMIN. CODE tit. 14, § 15.7(a) (1980).

45. *Id.* § 15.7(b). During the 72 hour period, the director must have two physicians examine the patient and report their findings and conclusions separately to him. *Id.*

46. See N.Y. MENTAL HYG. LAW §§ 9.21, 9.23 (McKinney 1978).

untary admission be the admission status of last resort, and that informal be preferred to voluntary admission, however, is realized only partially in New York City. Informal status is virtually never used. Several practitioners interviewed said that few patients understand the distinction between the voluntary and informal statuses well enough to know to ask for informal admission. They suggested that even though the hospital is obligated to explain these statuses to patients,<sup>47</sup> it often does not. Informal status is disfavored among practitioners in New York City because a disturbed patient simply may leave at any time, thereby terminating ongoing treatment. Some practitioners expressed concern that the hospital might be liable if a released informal patient harmed someone.<sup>48</sup>

Hospital staff reported that patients seldom are converted on hospital initiative, from involuntary to voluntary status. Staff are reluctant to convert patients to voluntary status unless they believe that the patients are sincerely motivated to accept treatment. Involuntary patients in New York sometimes convert to voluntary status in hope of signing themselves out of the hospital.

The law's preference for informal and voluntary admissions reflects the notion that care and treatment should be provided in the least restrictive manner. Unlike many jurisdictions,<sup>49</sup> New York does not provide involuntary patients with a comprehensive statutory right to the least restrictive treatment alternative, including a right to noninstitutional placement when appropriate. In fact, the Mental Health Act precludes the initial placement of an involuntary patient in a non-hospital setting.<sup>50</sup>

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47. See *id.* § 9.17(a)(3).

48. The supreme court, appellate division, however, has held that no such liability attaches. See *Paradies v. Benedictine Hospital*, 77 A.D.2d 757, 758, 431 N.Y.S.2d 175, 177, *appeal dismissed*, 51 N.Y.2d 1006, 417 N.E.2d 94, 435 N.Y.S.2d 982 (1980).

49. See, e.g., CAL. WELF. & INST. CODE § 5325.1(a) (West 1984); ILL. ANN. STAT. ch. 91 ½, § 2-102(a) (Smith-Hurd Supp. 1984-1985); MO. ANN. STAT. § 630.115(1)(10) (Vernon Supp. 1984); VA. CODE § 37.1-84.1(6) (Supp. 1983); WIS. STAT. ANN. § 51.61(1)(b)(3)(e) (West Supp. 1983-1984).

50. See N.Y. MENTAL HYG. LAW § 9.01 (McKinney 1978) (defining "in need of involuntary care and treatment" as having "a mental illness for which care and treatment as a patient in a hospital is essential" (emphasis added)). After initial placement in a hospital, a patient may be conditionally released into the community. See *id.* § 29.15 (McKinney Supp. 1983-1984).

The Court of Appeals of New York has recognized, however, that involuntarily committed patients have a due process right to the least restrictive institutional placement. In *Kesselbrenner v. Anonymous*,<sup>51</sup> the court held unconstitutional a statutory provision that authorized the confinement of a dangerously mentally ill person, who had been neither charged with nor convicted of a crime, in Matteawan State Hospital, a correctional facility for mentally ill convicts.<sup>52</sup> In reaching this result, the court said: "To subject a person to a greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined is, it is clear, violative of due process."<sup>53</sup> The court concluded that no reasonable relationship existed between such punitive confinement and the therapeutic purpose sought to be achieved.<sup>54</sup> In addition, the court quoted with approval from an opinion of the United States Court of Appeals for the District of Columbia:

[T]he principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil committment. . . . A statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly, even grudgingly, construed in order to avoid deprivations of liberty without due process of law.<sup>55</sup>

The court held that only confinement in a mental health facility was acceptable.<sup>56</sup> *Kesselbrenner* directly addressed the proper placement of an institutionalized patient.<sup>57</sup> Its rationale arguably applies, however, not to just *where* a patient should be placed, but to *whether* the patient should be subject to involuntary hospitalization. The Family Court of New York County

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51. 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973).

52. *Id.* at 167, 305 N.E.2d at 906, 350 N.Y.S.2d at 894.

53. *Id.* at 165, 305 N.E.2d at 905, 350 N.Y.S.2d at 892 (citing, *inter alia*, *Jackson v. Indiana*, 406 U.S. 715 (1972)).

54. *Id.* at 166, 305 N.E.2d at 905, 350 N.Y.S.2d at 892.

55. *Id.* at 167, 305 N.E.2d at 906, 350 N.Y.S.2d at 894 (quoting *Covington v. Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969)).

56. *Id.* at 167-68, 305 N.E.2d at 906-07, 350 N.Y.S.2d at 894.

57. Other jurisdictions also have recognized that the least restrictive alternative doctrine applies to alternate dispositions within the hospital. *E.g.*, *Covington* at 623-24; *Ploof v. Brooks*, 342 F. Supp. 999, 1005 (D. Vt. 1972). *See also* *Department of Health & Rehab. Servs. v. Owens*, 305 So. 2d 314 (Fla. Dist. Ct. App. 1974) (Boyer, J., dissenting); *Application of D.D.*, 118 N.J. Super. 1, 7-8, 285 A.2d 283, 287 (1971).

used a similar rationale in *In re Andrea B.*<sup>58</sup> to hold that a fourteen year old patient who challenged her continued involuntary hospitalization should be released because her needs could be met by services less restrictive than hospitalization. The court reasoned that "substantive due process requires adherence to the principle of the least restrictive alternative. The doctrine of least restrictive alternative comprehends not only the degree of physical restraint but the environment, including fellow patients, to which the individual is confined."<sup>59</sup> Furthermore, even though a governmental purpose is legitimate and substantial, it must not be achieved by "means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved."<sup>60</sup>

Although the precedential value of *In re Andrea B.* is dubious, the decision of the Court of Appeals in *Kesselbrenner* has implications regarding involuntary civil patients. *Kesselbrenner* qualifies the statutory language requiring hospital placement of involuntary patients<sup>61</sup> by suggesting that, on constitutional grounds, the particular hospital chosen must be the least restrictive appropriate setting, that the placement within that hospital be the least restrictive, and that the actual treatment administered be the least restrictive.<sup>62</sup>

Two cases currently pending in New York City go beyond *Kesselbrenner* and present the issue of whether patients are entitled to receive treatment in the least restrictive environment upon release or discharge from a psychiatric hospital. These cases, *Klostermann v. Cuomo*<sup>63</sup> and *Joanne S. v. Carey*,<sup>64</sup> were refiled in the supreme court after the court of appeals unanimously reversed the appellate division's holdings that the com-

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58. 94 Misc. 2d 919, 405 N.Y.2d 977 (N.Y. Fam. Ct. 1978).

59. *Id.* at 925, 405 N.Y.S.2d at 981 (citation omitted).

60. *Id.*

61. *Kesselbrenner*, 33 N.Y.2d at 167, 305 N.E.2d at 906-07, 350 N.Y.S.2d at 894 (explaining N.Y. MENTAL HYG. LAW § 901 (McKinney 1978)). See also *supra* note 50.

62. *Kesselbrenner*, 33 N.Y.2d at 167, 305 N.E.2d at 906-07, 350 N.Y.S.2d at 894.

63. *Klostermann v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984), *rev'g*, 91 A.D.2d 593, 458 N.Y.S.2d 190 (1st Dep't 1982) *refiled*, No. 11270/82 (Sup. Ct. N.Y. County 1984).

64. *Id.*, *rev'g*, *Joanne S. v. Carey*, 94 A.D.2d 691, 462 N.Y.S.2d 808 (1st Dep't 1983) *refiled*, No. 18493/82 (Sup. Ct. N.Y. County 1984).



plaints failed to present justiciable controversies.<sup>65</sup> The plaintiffs in *Klostermann*, were each treated in a psychiatric hospital and discharged, thereafter joining the homeless wandering the streets of New York City.<sup>66</sup> The plaintiffs contend that they are entitled under State law to receive appropriate residential placement, supervision, and care.<sup>67</sup> The plaintiffs in *Joanne S.*, who are currently hospitalized at the Manhattan Psychiatric Center, have been found ready for release or discharge, but have not been released or discharged because adequate residential placements are unavailable.<sup>68</sup> They seek their release into community treatment settings.<sup>69</sup> The plaintiffs in both cases seek to compel the development of sufficient community alternatives for the plaintiffs and the members of the classes they represent.<sup>70</sup>

Statutes of many states authorize the courts to order placement outside of a hospital.<sup>71</sup> For example, Virginia permits its courts to order "outpatient treatment, day treatment in a hospital, night treatment in a hospital, referral to a community

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65. The cases were consolidated for argument in the court of appeals, which only addressed the justiciability issue and not the merits of the plaintiffs' causes of action. See *Klostermann*, 61 N.Y.2d at 535, 463 N.E.2d at 593, 475 N.Y.S.2d at 252. If the merits are ultimately decided in favor of the plaintiffs, the results could be as far-reaching for the mentally ill as the *Willowbrook* consent decree has been for the mentally retarded. The *Willowbrook* consent decree was signed by then New York Governor Hugh L. Carey on April 22, 1975, and subsequently was approved by the United States District Court for the Eastern District of New York in *New York State Ass'n for Retarded Children v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975), *enforced*, 551 F. Supp. 1165 (E.D.N.Y. 1982), *aff'd in part and rev'd in part*, 706 F.2d 956 (2d Cir. 1983), *cert. denied*, 104 S. Ct. 277 (1983). The decree required, among other things, that the defendants "take all steps necessary to develop and operate a broad range of non-institutional community facilities and programs" to meet the needs of persons residing at the Willowbrook State Developmental Center, now the Staten Island Developmental Center. *Id.* at 717. Despite the defendants' failure to comply with the decree in several respects, see *New York State Ass'n for Retarded Children v. Carey*, 551 F. Supp. at 1167, 1192, the decree has resulted in the care for mentally retarded persons becoming primarily community-based rather than institution-oriented, see *id.* at 1168, and in a notable increase of community residences for the mentally retarded, see *id.* at 1188.

66. *Klostermann*, 61 N.Y.2d at 531, 463 N.E.2d at 591, 475 N.Y.S.2d at 250.

67. *Id.* These claims are based upon N.Y. MENTAL HYG. LAW § 29.15(f)-(h) (McKinney Supp. 1984-1985), which provides for the discharge and conditional release of patients to the community.

68. *Klostermann*, 61 N.Y.2d at 534, 463 N.E.2d at 592, 475 N.Y.S.2d at 251.

69. *Id.*

70. *Id.* at 533-34, 463 N.E.2d at 592, 475 N.Y.S.2d at 251.

71. See Miller & Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment*, 35 HOSP. & COMMUNITY PSYCHIATRY 147 (1984).

mental health clinic, or other such appropriate treatment modalities as may be necessary to meet the needs of the individual."<sup>72</sup> Several interviewees stated that, in principle, they would favor a statutory amendment giving New York courts this authority, but that it would make little practical difference until new alternative facilities and programs were developed.

The primary obstacle to application of the least restrictive alternative doctrine in New York is not that the statute fails to require it<sup>73</sup> or that the actors in the commitment process are insensitive to the merits of alternative treatment,<sup>74</sup> but that alternatives to the hospital are virtually nonexistent. For example, in the Bronx, 1,200 residential beds are needed but only 218 now exist. Alternatives such as community residential facilities<sup>75</sup> are drying up because of rising real estate costs in New York City<sup>76</sup>

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72. VA. CODE § 37.1-67.3 (1984). See also ARIZ. REV. STAT. ANN. § 36-540A (1983-1984); WIS. STAT. ANN. § 51.20(13)(a)(3)-(5)(West Supp. 1983-1984).

73. The statute provides mental patients an express right to less restrictive treatment only in one limited situation. That is, a patient may be placed in physical restraints "only if less restrictive techniques have been clinically determined to be inappropriate or insufficient to avoid" serious injury to the patient or others. N.Y. MENTAL HYG. LAW § 33.04(b) (McKinney Supp. 1983-1984). In addition to not requiring application of the least restrictive alternative doctrine in all cases, the New York statute, like those of most states, fails to define the doctrine within the mental health context. The definition varies among states that have defined it. For a representative sample of state definitions, see GA. CODE ANN. § 37-3-1(10) (1982); KY. REV. STAT. § 202A.011(7) (Interim Supp. 1982); MO. REV. STAT. § 630.005.1(18) (Vernon Supp. 1984); N.M. STAT. ANN. § 43-1-3(d) (1978).

74. See C. KIESLER, E. GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATIONS OF MENTAL PATIENTS AND OTHER INMATES* (1961). Goldstein, *The Sociology of Mental Health and Illness*, 5 ANN. REV. SOC. 381 (1979); Kiesler, *Mental Hospitals and Alternative Care: Non-institutionalization as Potential Public Policy*, 37 AM. PSYCHOLOGIST 349, 350 (1982); The New York Code of Rules and Regulations promulgated by the Commissioner of Mental Health aspire to shift the locus of mental health services away from institutional settings. See also N.Y. ADMIN. CODE tit. 14 § 36.1 (1982) ("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.").

75. "'Community residential facility' means any facility subject to licensure by the office of mental retardation and developmental disabilities which provides a supervised residence or residential respite for services for mentally disabled persons. Such term does not include family care homes." N.Y. MENTAL HYG. LAW § 41.36(a)(1) (McKinney Supp. 1983-1984).

76. Single room occupancy hotels and apartments that were once converted into community residential facilities are now being converted into condominiums and cooperatives, thereby reducing the number of available units and driving up their costs.

and because of insufficient state funding appropriations.<sup>77</sup> Also, the alternatives that are available are plagued by long waiting lists and formidable bureaucratic intake requirements that can result in placement delays of one to two months or more.<sup>78</sup> The creation of more alternatives is an obvious prerequisite to the effectiveness of legal or regulatory reforms aimed at promoting the use of alternative treatment.<sup>79</sup> Under the existing statutory admission scheme, however, whenever appropriate, hospital staff and MHIS attorneys should explain fully to respondents their option of entering the hospital on an informal or voluntary basis.

### E. Prehearing Examinations

At least two examinations are required when an emergency admission is sought, the first prior to admission and the second within forty-eight hours.<sup>80</sup> To retain a patient involuntarily beyond the fifteen day emergency hospitalization period, the two-physician certification procedure must be used.<sup>81</sup>

Two physician's certificates in New York often include general and insubstantial information. In addition, the certificates frequently are not filed within the fifteen days allowed. Typically, however, judges overlook such "technicalities" and consider cases on the merits.

The emphasis on multiple and independent examinations in

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77. See Brief for Plaintiffs-Appellants at 4, n.\*, *Joanne S. v. Carey, consolidated on appeal with Klosterman v. Cuomo*, 61 N.Y.2d 525, 463 N.E.2d 588, 475 N.Y.S.2d 247 (1984) ("There is also evidence that the state is not even using all of the money currently appropriated for the development of community residences.") (citation omitted). In addition, the federal government spends over 70% of its mental health funds on hospitalization. Kiesler, *supra* note 74, at 1323.

78. The delay results from the time required to process a "Request for Residential Placement" (Form 418) through the Department of Social Services. Each placement decision made by the Department of Social Services is based on a Form 418, not on a clinical examination of the patient.

79. The Local and Unified Services Law, N.Y. MENTAL HYG. LAW art. 41 (McKinney 1978), requires extensive planning of community residential and treatment services but does not actually require creation of services themselves. See, e.g., *id.* § 41.21. Furthermore, state matching funds for construction costs and other capital expenditures connected with creating these services, *id.* § 41.03(9), must be authorized by the legislature after the Commissioner of Mental Health has requested and the Governor has recommended the appropriations. See *id.* § 41.27.

80. N.Y. MENTAL HYG. LAW § 9.39(a) (McKinney 1978).

81. See *id.* § 9.39(b) (McKinney 1978).

the prehearing stage is a strength of the commitment system in New York. Given the imprecision of the clinical endeavor, particularly as it concerns the prediction of future behavior,<sup>82</sup> the reliability of commitment decisionmaking should rise with the number of clinical opinions presented. This assumes, of course, that each examiner conducts a thorough and competent evaluation.

A problem with these examinations in New York is the difficulty some foreign-born examining physicians have communicating clearly in English. There is an obvious risk that the patient who fails to understand the physician who examines him will also fail to provide reliable information. In addition, the physician who is unable to grasp the meaning of statements made by his patient is likely to arrive at an imperfect diagnosis opinion. Finally, unless the physician is able to communicate his opinion clearly in court, the judge's decision may be misinformed. Therefore, examining physicians should be fluent in both oral and written English.

Requiring fluency among the medical staff may resolve the problems of communication only partially, however. Many people who become respondents in New York City commitment proceedings speak English poorly or not at all. These people require an interpreter or a physician who speaks their language. In hospitals with large non-English speaking populations, stand-by interpreters and bilingual physicians are available. In many hospitals, however, the cost of providing such a service may be prohibitive. A better solution may be to maintain a list of interpreters available in the community to assist in the evaluation of non-English speaking respondents. In any event, if an interpreter is needed, it should be the responsibility of the hospital to arrange for one.

Another aspect of prehearing examinations is the right of respondents to seek an independent medical opinion.<sup>83</sup> In New York, a judge may appoint a physician to examine the respondent upon the respondent's request. The judge selects an examiner from a list maintained by the court. Independent examina-

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82. See J. MONAHAN, *PREDICTING VIOLENT BEHAVIOR: AN ASSESSMENT OF CLINICAL TECHNIQUES* (1981).

83. N.Y. MENTAL HYG. LAW § 29.09(b)(2) (McKinney 1978).

tions seldom are requested, however, because arranging such an examination may delay the commitment hearing for a week or more. MHIS attorneys recommend independent examinations only in exceptional cases because the independent examiner's findings usually agree with those of the hospital examiner, and thereby reinforce the state's case for commitment.<sup>84</sup>

A weakness of the New York statutory scheme is the failure to provide respondents the right to refuse to speak with the hospital's examining physician. As a matter of practice, physicians in New York do not recognize such a right and, accordingly, do not advise the respondent of any such right prior to the evaluation.

In several states, respondents have the right to remain silent during prehearing evaluations.<sup>85</sup> Even in jurisdictions where no such legal right has been recognized, many believe that the examining physician has an ethical duty to advise the respondent how statements made during the evaluation will be used. Patients often are bewildered and confused during the early stages of the commitment proceeding. The "silent treatment" given them by staff of the detaining facility serves only to increase resentment and noncooperation. Despite the suggestion that informed patients will be discouraged from answering questions truthfully, many examiners report that respondents appreciate the honesty of a physician who is forthright and become more cooperative and trusting as a result.<sup>86</sup>

Controversy surrounds the issue of doctor-patient privilege applying to communications between a respondent and examiner. Most scholars deny any such privilege exists during a court-ordered evaluation.<sup>87</sup> If the examining physician is also the

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84. Because of the infrequency of independent examinations, it is impossible to estimate how frequently they would disagree with the initial hospital examinations.

85. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078, 1100-02 (E.D. Wis. 1972).

86. PROVISIONAL GUIDELINES, *supra* note 9, at II-46.

87. See, e.g., Orland, *Evidence in Psychiatric Settings*, 11 GONZ. L. REV. 665, 685-86 (1976); Note, *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1303-13 (1974). See also Proposed Rule of Evidence, Rule 504(d)(3), reprinted in 56 F.R.D. 183, 241 (1972) (exception to psychotherapist-patient privilege). Other commentators concede the nonexistence of the privilege during court-ordered evaluations but suggest that these evaluations are inherently coercive. See Aronson, *Should the Privilege Against Self-Incrimination Apply to Compelled Psychiatric Examination?*, 26 STAN. L. REV. 55, 70-71 (1973); Smith, *Constitutional Privacy in Psycho-*

treating physician, however, the matter is not so clear. Laws in a few states prevent the treating physician of a respondent from evaluating him in a commitment proceeding.<sup>88</sup> In Columbus, Ohio, for example, each respondent is examined by a "court doctor" and by an "independent doctor."<sup>89</sup> The independent doctor is bound by the doctor-patient privilege; the court doctor is not. So long as the treating physician explains to his patient before beginning the evaluation that he will provide the results of the evaluation to the court, there should be no objection to the testimony of the treating physician in court.<sup>90</sup> If, however, he has not so advised his patient, he may violate ethical standards by revealing his findings.<sup>91</sup>

As a general matter, though, the prehearing examination effectively screens many persons who do not meet the criteria for commitment. Almost half of all persons presented for emergency involuntary admission at Bellevue Hospital are screened out and discharged as a result of the initial examination. Of those admitted involuntarily, the majority are discharged within fifteen days, regardless of whether a hearing is held.

#### F. Prehearing Treatment

In many states, involuntary patients are accorded a qualified right to refuse treatment prior to an adjudication of committability.<sup>92</sup> The New York statutes are silent regarding

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therapy, 49 GEO. WASH. L. REV. 1, 57-58 (1980).

88. See, e.g., N.C. GEN. STAT. § 122-58.3(d) (1981).

89. See I. KEILITZ, OHIO, *supra* note 8, at 9 (1982).

90. Requiring examining physicians to explain the nature, purpose, and consequences of their examination, may improperly cast physicians in the role of patient counsel. Perhaps this function would be more properly, and probably more effectively, handled by the MHIS. If the MHIS can give each patient an accurate and clear explanation of the nature, purpose, and consequences of the examination, that would be sufficient. What is important is that each respondent receives the explanation. We recommend the physician give that explanation only because he seems in a better position to provide it.

91. See, e.g., American Medical Association, *Principles of Medical Ethics* § 9 (1957), reprinted in 4 ENCYCLOPEDIA OF BIOETHICS 1751 (W.T. Reich ed. 1978); American Psychiatric Association, *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* § 9, reprinted in 130 AM. J. PSYCHIATRY 1057, 1063 (1973). See also Comment, *Status of the Emergency Room Psychotherapist: Privacy Rites*, 30 UCLA L. REV. 1316 (1983), (mental patients' right to privacy considered from perspective of the psychotherapist).

92. See Perr, *Refusing Treatment — Who Shall Decide?*, 10 AM. ACAD. PSYCHIATRY

whether patients may be treated during the prehearing period. As a matter of practice, treatment ordinarily begins soon after a patient is admitted and continues throughout the commitment period, regardless of whether the commitment is contested in a hearing.

The narrower issue of whether patients should be under the influence of medication during hearings is a controversial question. Some argue that a properly medicated respondent is better able to understand the proceedings and assist in his defense. Critics contend that although medication may enable the respondent to think more clearly, its side effects may create an appearance of mental illness regardless of the respondent's true condition. If the respondent is medicated during the prehearing period, the treating physician should inform the court, the respondent's attorney, and the attorney representing the state or the hospital what medications were administered and what consequences these medications are likely to have on the respondent's behavior during the hearing and on his ability to assist counsel.<sup>93</sup>

### III. Counsel for the Respondent

#### A. *Mental Health Information Service*

Respondents in New York are entitled to the assistance of counsel throughout the commitment process. Immediately upon admission to the hospital, a respondent may consult an attorney regarding his or her right to challenge the hospitalization in court. If a respondent initiates such a challenge, he or she is en-

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& L. BULL. 233 (1982); Hassenfeld & Grumet, *A Study of the Right to Refuse Treatment*, 12 AM. ACAD. PSYCHIATRY & L. BULL. 65, 66-67 (1984); Rockford, *More on the Right to Refuse Treatment: Brother Fox and the Mentally Ill in New York*, 11 LAW, MED. & HEALTH CARE 19 (1983).

93. This recommendation is not intended to remedy the lack of any statutory language relating to prehearing patient treatment. Its intent is more limited: if the respondent is under the influence of medication, what would be done to preserve the integrity of the commitment hearing? This narrower issue is the less controversial.

The broader issue involves balancing of the respondent's right to be free of unwanted medication and the state's interest in protecting the mental health of its citizens. One way of achieving this balance may be to define the types of medication which may be administered pending hearing rather than to define the required nature of patient conduct.

titled to be represented by counsel at the hearing.

Although not required to do so by statute, MHIS attorneys in New York City generally represent patients in commitment hearings. The statute directs the MHIS to: (1) study the admission and retention of all patients, (2) inform patients of their rights, (3) provide the court with all relevant information about the patient,<sup>94</sup> (4) provide services and assistance to patients and their families, and (5) investigate cases of alleged patient mistreatment and take legal action to protect patients.<sup>95</sup> Additionally, the MHIS also employs social workers who investigate alternative treatment programs and, when appropriate, work with the legal staff to pursue transfer of patients to less restrictive settings. This function of the MHIS, though less visible than that of providing legal representation, is vitally important if the least restrictive alternative doctrine is to have any meaning in New York.<sup>96</sup>

All involuntary patients in New York must be advised at the time of admission of the availability of assistance from the MHIS.<sup>97</sup> The involuntary patient may use the MHIS throughout his hospital stay.<sup>98</sup> Indeed, upon receipt of a patient's record,<sup>99</sup> the MHIS becomes the patient's legal representative until he is discharged or becomes a voluntary patient.

MHIS attorneys are available to represent all patients, regardless of their financial abilities. While, of course, patients are entitled to retain private legal assistance, some MHIS attorneys advise against the retention of private counsel because so few have any meaningful knowledge or experience in the mental health law field. In the event that a private attorney becomes involved in a commitment case, the court may request that the MHIS attorney continue in an advisory role.

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94. Whenever a commitment hearing is scheduled, the MHIS staff prepares a memorandum consisting of: a brief history of the patient, a summary of the medical staff's reasons for seeking retention of patient, and any arrangements that might advance the patient's release.

95. N.Y. MENTAL HYG. LAW § 29.09 (McKinney 1978).

96. This function is discussed more fully *infra* notes 132-133 and accompanying text.

97. N.Y. MENTAL HYG. LAW § 9.07 (McKinney 1978).

98. *Id.*

99. An involuntary patient's record must be sent to the MHIS within five days of his admission. N.Y. MENTAL HYG. LAW § 9.11 (McKinney 1978).



## B. *Role of Counsel*

Because of their varied responsibilities, MHIS attorneys are highly vulnerable to charges of conflict of interest. Of particular concern is their dual responsibility for representing the patient and providing relevant information regarding the patient's case to the court. Most observers in New York City agree, however, that MHIS attorneys are able to provide the court with the information it needs without compromising the patient's right to a fair hearing.<sup>100</sup>

The MHIS attorneys act as zealous advocates for their clients' expressed wishes. Although they ordinarily argue for release of their clients, they bristle at the suggestion that they are insensitive to their clients' best interests. They frequently advise clients to accept a period of needed hospitalization, but once a client has decided to contest the hospitalization, their responsibility as counsel leaves no choice but to argue for release.<sup>101</sup>

Occasionally, the adversarial stance of the attorneys leads to friction between the MHIS and the medical staff. While not always pleasant, such friction is healthy when the issue is treatment on the one hand and liberty on the other.

## IV. The Hearing: Determining Committability

### A. *When Hearings Are Held*

New York law does not provide for "automatic" commitment hearings. Rather, commitment hearings are held only upon the request of the patient, any relative or friend of the patient, or the MHIS.<sup>102</sup> Hearings to challenge emergency admissions may be requested anytime after admission;<sup>103</sup> hearings to chal-

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100. 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 wishes.

101. Attorneys are ethically bound to advise clients regarding available options and then to zealously pursue the course of action desired by the client. See MODEL CODE OF PROFESSIONAL RESPONSIBILITY Canon 7 (1980). See also Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and A Proposal*, 45 MISS. L.J. 43 (1974); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CALIF. L. REV. 816 (1974); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L.J. 1540 (1975).

102. N.Y. MENTAL HYG. LAW §§ 9.31, 9.39 (McKinney 1978).

103. *Id.* § 9.31(a).

lenge admission on a two-physician certification may be requested anytime within sixty days of admission.<sup>104</sup>

In New York City, few involuntary hospitalizations entail hearings. Hearings are rare for several reasons. The MHIS staff may persuade the patient not to contest the hospitalization, either because it would be futile or because the best interests of the patient call for a period of treatment in the hospital. Other cases are settled, often with placement of the patient in a less restrictive treatment program.<sup>105</sup>

New York is one of only a few states that permit involuntary hospitalization without a court hearing.<sup>106</sup> Given the presence of the MHIS in the hospitals, requiring a hearing in every case may be unnecessary. In addition, the burden that automatic hearings would place on the courts and the hospital personnel who would have to participate in them may be prohibitive.

While courts in some jurisdictions have ruled that automatic hearings are constitutionally required,<sup>107</sup> the United States Court of Appeals for the Second Circuit has upheld the New York procedure.<sup>108</sup> For the New York procedure to protect adequately the liberty interests of involuntary patients, however, it is essential that the MHIS staff make themselves available to every involuntary patient. It is not enough that the patient be advised of the availability of the MHIS; without the individual assistance of someone from the MHIS, the patient cannot be expected to make an informed and intelligent decision about whether to challenge the commitment.

Automatic hearings in and of themselves do not make the commitment process better or fairer; indeed, in many jurisdictions, mandatory hearings are pro forma exercises. Also, a full, adversarial hearing is a costly endeavor. Requiring a hearing in every involuntary civil commitment case may severely burden

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104. *Id.* § 9.39(a).

105. The MHIS social workers play a key role in locating alternatives to hospitalization and, thus, in effecting release. The least restrictive alternative doctrine 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.

106. In most states a hearing must be held within about five days of the patient's admission. PROVISIONAL GUIDELINES, *supra* note 9, at IV-6.

107. See, e.g., *Doe v. Gallinot*, 657 F.2d 1017 (9th Cir. 1981).

108. *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983).

the courts, the hospitals, and the MHIS, and might *guarantee* pro forma hearings. Because of the loss of liberty and potential for stigma that results from involuntary commitment, however, it is perhaps better to risk clogged dockets than improper commitment. Nevertheless, if the MHIS attorneys carefully consider each case and insist on a hearing for every case in which the patient's committability is questionable, the utility of the New York procedure may outweigh the dangers of not having automatic hearings.

### B. *Characteristics of Hearings*

A respondent's request for hearing must be given in writing to the hospital director, who promptly forwards it and a copy of the patient's record to the court and the MHIS. The court then schedules a hearing within five days from the date it receives the request.<sup>109</sup>

Commitment hearings are held weekly at Bellevue Hospital and at Manhattan Psychiatric Center. Hearings generally are not held in the other hospitals in Manhattan.<sup>110</sup> Patients in those hospitals must be transported to Bellevue or Manhattan Psychiatric Center, and testifying physicians, hospital security guards, and MHIS staff must travel there. Patients from other hospitals who request hearings and are only marginally committable often are released to avoid the inconvenience of a hearing. As a result, the proportion of involuntary patients from Bellevue and Manhattan Psychiatric Center whose cases are heard in court is said to be considerably higher than that from other hospitals in Manhattan.

The location of hearings should not be determined only by convenience to the court and hospital, but should also take into account the interests of the patient. Holding hearings in other hospitals would avoid the problems of patient transport and spare patients the indignities and discomfort of supervised transportation. Because hospital staff rarely attend hearings held at other hospitals, a patient may lose his opportunity to confront and cross-examine key witnesses. Alternatively, hospi-

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109. N.Y. MENTAL HYG. LAW §§ 9.31, 9.39 (McKinney 1978).

110. On rare occasions, however, the court hears cases in these other hospitals when warranted by special circumstances.

tals may discharge patients rather than subject their staff to the inconvenience of attending hearings in other facilities. This occurs frequently in New York City.

Commitment hearings, which are generally closed to the public, are conducted by justices of the New York Supreme Court. Typically present at hearings are the respondents, five or six attorneys, four or five psychiatrists, several police and security officers, and several court personnel. Hearings are informal and somewhat disorganized. In a number of cases observed by the authors, necessary commitment papers (physician certificates) were unavailable, hearing participants were not prepared to go forward when cases were called, and, in some cases, patients were not present in court. As a result, valuable court time was wasted, general confusion prevailed, and cases were sometimes adjourned until later in the day or the next week. On a typical hearing day, about twenty cases are scheduled 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 statute provides that hearings may be adjourned for an unspecified period of time.<sup>111</sup> Hearings on emergency admissions may be adjourned only upon request of the patient;<sup>112</sup> hearings on two-physician certification admissions may be adjourned upon the request of either the patient or the hospital.<sup>113</sup> Requests for adjournment are common in New York City. MHIS attorneys request them to arrange placement in community treatment programs. Hospital attorneys request them if the required paperwork is incomplete or the necessary medical witnesses are unavailable. In addition, judges sometimes adjourn cases simply because they are unable to remain at the hospital long enough to hear all the cases on the docket. As a result, cases frequently are not heard until several weeks after the request for hearing is made. This overuse of adjournments is the single most deficient feature of the New York commitment system.

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111. N.Y. MENTAL HYG. LAW §§ 9.31(c), 9.39(a) (McKinney 1978).

112. *Id.* § 9.39(a).

113. *See id.* § 9.31(c).

### C. *Criteria for Commitment*

The criterion for emergency admission in New York is mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to self or others.<sup>114</sup> "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) 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.<sup>115</sup>

"In need of care and treatment" means that a person has a mental illness for which inpatient care and treatment in a hospital is appropriate.<sup>116</sup>

The criteria for involuntary admission on a two-physician certification are that the respondent is mentally ill and in need of involuntary care and treatment.<sup>117</sup> "'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 is unable to understand the need for such care and treatment."<sup>118</sup> Although dangerousness is not specified by statute as a requirement for involuntary commitment on a two-physician certification, the appellate division of the supreme court has ruled:

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

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114. *Id.* § 9.39(a).

115. *Id.*

116. *Id.* § 9.01.

117. *Id.* § 9.27(a).

118. *Id.* § 9.01.

his own well-being.<sup>119</sup>

The burden of proof in the commitment proceedings is on the state. In emergency admissions hearings the standard of proof is "reasonable cause to believe" that the criteria are satisfied.<sup>120</sup> In medical certification hearings the standard of proof is clear and convincing evidence.<sup>121</sup> The reasonable cause standard is used in other jurisdictions only in probable cause hearings to determine whether a patient should be detained, but not committed for purposes of treatment, pending a hearing on the question of commitment.<sup>122</sup> The United States Supreme Court has ruled that, because commitment entails a "massive curtailment of liberty," the state must establish committability by clear and convincing evidence.<sup>123</sup> The statutory standard of proof for emergency admission in New York, therefore, may be constitutionally unsound.

Observers in New York report that the judges reliably apply the appropriate criteria when making commitment decisions. When a judge hears a case, he has before him an MHIS trial memorandum that sets forth the precise standard and the questions presented. Nevertheless, in hearings observed by the authors, the judges did not always clearly address the criteria requiring proof. Whether respondents in two-physician certification proceedings were able to understand the need for care and treatment was overlooked in virtually every case.

#### D. *Counsel for the Hospital*

Cases involving patients at state hospitals are handled by attorneys from the New York Attorney General's Office. Municipal and private hospitals, however, are not always represented. In recent years, the judges have begun to require the presence of counsel for the hospital in every commitment case. Attorneys

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119. *Scopes v. Shah*, 59 A.D.2d 203, 205, 398 N.Y.S.2d 911, 913 (1977) (citations omitted).

120. N.Y. MENTAL HYG. LAW § 9.39(a) (McKinney 1978).

121. *Scopes*, 59 A.D.2d at 206, 398 N.Y.S.2d at 913-14.

122. See, e.g., *Lynch v. Baxley*, 386 F. Supp. 378, 387-88 (M.D. Ala. 1974); *Bell v. Wayne County Gen. Hosp.*, 384 F. Supp. 1085, 1098 (E.D. Mich. 1974); *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

123. *Addington v. Texas*, 441 U.S. 418, 431-33 (1979).

from the Office of General Counsel of the City's Health and Hospitals Corporation now appear in commitment cases involving patients in city hospitals. Private attorneys appear on behalf of the private hospitals.

Nothing in the law in New York requires that the hospital be represented at the hearing. Reportedly, the practice of attorney representation of the hospital has developed out of a concern that, in the absence of this representation, the prosecuting function would be performed by the judge or the psychiatrist, whose objectivity would then be called into question.

### E. *Assignment of Judges*

Commitment cases are heard on a rotating basis by justices of the civil division of the supreme court. Judges in Manhattan ordinarily hear commitment cases for one week and then move on to other assignments. Because no one judge presides very often, there is little opportunity for the development of an expertise in commitment law and practice among the judges. Reportedly, judges in the Bronx are assigned to hear commitment cases for two months each year. As a result, judges in the Bronx are much more sensitive to the unique issues in civil commitment than are judges in Manhattan.

There is general agreement that the quality and knowledge of the judges who preside over commitment proceedings in Manhattan varies greatly. Attorneys and mental health professionals alike are critical of many judges for knowing little of the applicable law. Others are 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 civil commitment law. Additionally, lunchtime seminars are held occasionally to educate judges. Still, many observers in New York City 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 and a different judge is sitting, the "sense" of the case is lost. Essentially, the proceeding must begin anew. The MHIS attorneys favor the rotation system, however, for fear that a permanent judge might, by chance, be the "wrong" judge and some patients

would never be released. Although the present system seems ripe for judge-shopping,<sup>124</sup> the MHIS attorneys report that it rarely occurs because (1) the attorneys often do not know which judges will be sitting from week to week, and (2) very few patients are willing to remain in the hospital an additional week on the chance of getting a more sympathetic judge.

#### F. *Witnesses at the Hearing*

The New York statutes do not require the presence of medical experts at commitment hearings. In practice, however, an examining or treating psychiatrist — typically the chief psychiatrist of the patient's hospital ward — is present to testify in virtually every case. In addition, the court receives the certificates of physicians whose examinations are required by law.<sup>125</sup>

Although the proper role of the testifying psychiatrist is to present medical evidence in a neutral manner, observers in New York City believe that psychiatrists there feel obligated to support the case for commitment and direct their testimony accordingly. Many of these psychiatrists apparently do not understand how the adversary system is supposed to work and naturally become defensive when their expertise is called into question. The consensus among judges in New York is that psychiatrists who present neutral testimony are the most persuasive.

Some New York judges believe that the examiner's testimony should be the key factor influencing the court. Others are more interested in the testimony of family members and other lay witnesses about specific examples of the patient's abnormal behavior. Too often, however, these witnesses are not available at the hearings, and the judge must rely on unsubstantiated allegations for this evidence.

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 for the court. Mental health professionals who testify in commitment cases frequently have had no formal

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124. "Judge-shopping" in this context is the practice of continuing a case for hearing on a day when a more sympathetic judge is sitting.

125. See N.Y. MENTAL HYG. LAW § 9.27 (McKinney 1978).



training in the law and do not understand what is expected of them in the commitment hearing. The presentation of orientation programs for hospital personnel on topics in the area of law and psychiatry could go far toward helping physicians both feel comfortable in court and provide higher quality information. Accordingly, staff of the MHIS in cooperation with counsel for the psychiatric hospitals in the city develop and conduct orientation or education programs for mental health professionals working in the city hospitals.

### G. *Rules of Evidence and Procedure*

Because of the relatively informal manner in which hearings are conducted, judges sometimes 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."<sup>126</sup>

Commitment hearings should not be entirely exempt from the rules of evidence and procedure applicable in other civil proceedings. 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 too strictly. Information about previous psychiatric treatment is almost always considered, although MHIS attorneys often object to introduction of this evidence on the ground that it is irrelevant and prejudicial. Of course, information about previous treatment is highly relevant to the court's understanding of a patient's diagnosis, prognosis, and treatment plan. Indeed, given the chronicity of many mental disorders, it is inescapable that previous psychiatric involvement would be considered.

A more compelling issue concerns the admissibility of hearsay statements in support of an allegation of dangerousness or other behavioral dysfunction. Commitment cases frequently are based on the allegations of family members or other acquaintances of the patient and often grow out of ongoing personal disputes. As a result, the allegations and the testimony provided by

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126. See *supra* note 11.

lay witnesses may not always be entirely objective. Because of this and because the emotional state of patients at the time of the hearing may hinder their capacity to refute false testimony, one would expect that judges would exclude evidence of this type. However, observers in New York report that most judges will admit this evidence. To the extent that witnesses to the patient's behavioral dysfunction are available, judges should insist on their *personal* testimony, not only out of fairness to the defense, but out of a concern for accuracy.

## V. The Hearing: Determining Treatment

### A. *Considering Less Restrictive Alternatives*

The interests of neither the patient nor society are served if the treatment ordered is more intrusive or expensive than necessary. The Mental Health Act does not require the court to consider alternatives to inpatient treatment, nor does it permit the court to order alternatives.<sup>127</sup> The least restrictive alternative doctrine is apparent in the statutory provisions for hearings following involuntary admission on medical certification in only one limited respect: if the court determines that "relatives of the patient or a committee of his person are willing and able properly to care for him 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 relatives or such committee."<sup>128</sup> Because "transfer" is not defined it is unclear from the face of the provision whether transfer to relatives or a committee constitutes a "release," meaning mere termination of inpatient care,<sup>129</sup> or "discharge," meaning release *and* "termination of any right to retain or treat the patient on an in-patient basis."<sup>130</sup> Thus, it is unclear whether a court's exercise of this provision would result in an involuntary placement less restrictive than inpatient care or merely an absolute discharge.

This is the only provision in the New York statute that even suggests that a hearing court might order placement less restric-

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127. See *supra* notes 69-70 and accompanying text.

128. N.Y. MENTAL HYG. LAW § 9.31(c) (McKinney 1978).

129. *Id.* § 1.03(29).

130. *Id.* § 1.03(31).

tive than hospitalization. Section 9.01 implies, however, that the court's authority is limited to deciding whether treatment *in a hospital* is appropriate and would not permit involuntary placement outside of a hospital. This interpretation is applied in New York City. In any event, the court rarely orders a patient discharged to his family because the family is usually absent. When the court does order discharge, it does not follow any established procedure. Rather than requiring written consent as provided by statute,<sup>131</sup> the court typically asks the family members present if they will care for the patient, and evaluates their sincerity.

As a practical matter, judges in New York City view less restrictive alternatives as a threshold question; that is, if a less restrictive placement is appropriate and available, involuntary retention is not ordered.<sup>132</sup> In each case, MHIS attorneys who represent patients at retention hearings, prepare a memorandum for the court which quotes a New York Code of Rules and Regulations provision that expresses a right to treatment in the least restrictive setting.<sup>133</sup> At the hearing, an MHIS attorney may challenge an examining physician's testimony regarding alternatives through cross-examination, or may actually present an alternative treatment plan to the court. One judge interviewed stated that the MHIS usually do not realistically present detailed alternatives to the court, but that in a borderline case he would be receptive to such a presentation. He suggested that the MHIS seldom inquire into community alternatives, but rather

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131. *Id.* § 9.31(c).

132. This is consistent with the holdings in several federal court cases that a court may not commit to involuntary treatment anyone for whom a less restrictive alternative is appropriate. *See, e.g.,* Covington v. Harris, 419 F.2d 617, 623-24 (D.C. Cir. 1969); Lake v. Cameron, 364 F.2d 657 (D.C. Cir. 1966); Phillip v. Carey, 517 F. Supp. 513, 517-18 (N.D.N.Y. 1981); Kenny v. Warden, Richmond City Jail, 476 F. Supp. 197 (E.D. Va. 1979); Institutionalized Juveniles v. Secretary of Pub. Welfare, 459 F. Supp. 30 (E.D. Pa. 1978), *rev'd on other grounds*, 442 U.S. 640 (1979); Lessard v. Schmidt, 379 F. Supp. 1376, 1380 (E.D. Wis. 1974); Lynch v. Baxley, 386 F. Supp. 378, 392 (M.D. Ala. 1974).

133. N.Y. ADMIN. CODE tit. 14 § 36.1 (1982). The Code provides in part:

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 of 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.

*Id.* This regulatory provision has no parallel in the New York statutes.

present legalistic, "boiler plate" arguments.

An MHIS representative, on the other hand, stated that in most hearings they are forced to hammer away at the legal commitment criteria because of lack of available alternatives. He stated that the MHIS frequently does investigate alternatives, but that it is difficult to arrange for a patient to be accepted in a community treatment program before the hearing. Understandably, many judges are reluctant to refrain from ordering retention simply because a community program exists that might be appropriate for the patient. Most judges require some assurance that the patient will be accepted by and enter the program before they will order the patient's discharge.

### B. *Presenting A Treatment Plan*

The criteria for involuntary commitment in a number of states require a showing that a respondent's debilitating condition is one for which appropriate treatment is available.<sup>134</sup> The United States Supreme Court has suggested, at least with respect to nondangerous mentally ill persons that involuntary commitment without the administration of treatment designed to address a person's disorder is unconstitutional.<sup>135</sup> It is largely

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134. See, e.g., *Halderman v. Pennhurst State School & Hosp.*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 451 U.S. 1 (1981); *Scott v. Plante*, 532 F.2d 939 (3d Cir. 1976), *subsequent appeal*, 641 F.2d 117 (3d Cir. 1981); *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), *vacated*, 422 U.S. 563 (1974), *vacated sub nom. Gumanis v. Donaldson*, 422 U.S. 1052 (1974); *In re Curry*, 452 F.2d 1360 (D.C. Cir. 1971); *Association for Retarded Citizens v. Olson*, 561 F. Supp. 470 (D.N.D. 1981); *Johnson v. Solomon*, 484 F. Supp. 278 (D. Md. 1979); *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980); *Eckerhart v. Hensley*, 475 F. Supp. 908 (W.D. Mo. 1979); *Lora v. Board of Ed.*, 456 F. Supp. 1211 (E.D.N.Y. 1978), *vacated*, 623 F. 2d 248 (2d Cir. 1980); *Eubanks v. Clarke*, 434 F. Supp. 1022 (E.D. Pa. 1977); *Gary W. v. State*, 437 F. Supp. 1209 (E.D. La. 1976); *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975); *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *aff'd in part and remanded in part*, 503 F.2d 1305 (5th Cir. 1974).

135. *O'Connor v. Donaldson*, 422 U.S. 563, 573-76 (1975). Specifically, the Court said: "[A] State cannot constitutionally confine *without more* a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Id.* at 576 (emphasis added). The Court ignored, however, the "quid pro quo" rationale established by preceding cases, such as *Rouse v. Cameron*, 373 F.2d 451, 458 (D.C. Cir. 1966), and *Wyatt v. Stickney*, 325 F.2d at 784. The quid pro quo theory, that if the state deprives a person of liberty by committing him for treatment, the state must provide treatment, was first propounded in Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499, 502-04 (1960).

because of the 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 the respondent's condition.

The New York statutes require hospitals to develop and maintain treatment plans for all patients, but fail to require that these plans be presented at commitment hearings.<sup>136</sup> Although testifying physicians typically are prepared to discuss their plans for treatment if and when the court requests this information, it is not standard procedure for the courts to make such requests.<sup>137</sup> The courts should inquire into the treatment plan to determine whether inpatient hospitalization is adequately addressing the respondent's needs.

Judicial orders of commitment do no more than bind a patient to the care of a hospital. 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 believe the judges should inquire more actively into whether the hospital plans to treat the respondent in the least restrictive setting within the hospital.<sup>138</sup>

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136. N.Y. MENTAL HYG. LAW § 29.13 (McKinney 1978). Treatment plans must include a statement of treatment goals, an indication of the treatment or therapies to be undertaken to meet these 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 with an opportunity to actively participate in the preparation and revision of treatment plans. *Id.* Treatment plans are developed and maintained in the city facilities essentially as required by statute.

137. One judge, however, stated that he always inquires into the kind of treatment that would be provided for the patient and how much time would be needed for the treatment to be completed.

138. The court's involvement with the institution generally ends with the commitment order. Treatment facilities retain the right to refuse to accept patients into their programs and if accepted, to select and manage their treatment. Private hospitals in

## VI. Posthearing Concerns

### A. *Right to Appeal*

The New York statutes provide that any person who has been denied release, or any relative or friend on the person's behalf, may obtain a rehearing within thirty days.<sup>139</sup> The rehearing process is initiated by petitioning a supreme court justice other than the one presiding over the court that made the original order.<sup>140</sup> This rehearing process permits prompt correction of mistakes made at the initial hearing. Orders resulting from review hearings may be appealed to the appellate division of the supreme court.<sup>141</sup>

Review hearings are by juries unless the patient or other person applying for review consents in writing to trial by the court.<sup>142</sup> As a practical matter, juries are almost never summoned. Reportedly, this is because juries cause delay and are viewed by the MHIS staff as less inclined to release respondents.

Rehearings are rare and appeals are even rarer. Because the appellate process takes so long,<sup>143</sup> appeals are almost never taken to pursue a patient's interest in release. Rather, appeals are taken to settle points of law.<sup>144</sup>

### B. *Transfers*

The transfer of patients between hospitals leads to constant controversy in New York City. Hospitals in the city serve particular geographic areas. A hospital may refuse admission to anyone from outside its area. If the police present a person for admission to Bellevue Hospital, for example, Bellevue personnel may transfer the person to a hospital that is within that person's

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New York City prefer to work voluntary patients, and generally do not accept patients whose hospitalization is court-ordered. Similarly, state hospitals exercise discretion in receiving patients committed initially in city hospitals.

139. N.Y. MENTAL HYG. LAW § 9.35 (McKinney 1978).

140. *Id.*

141. *See id.*

142. *Id.*

143. Reportedly, an appeal to the appellate division requires about one year.

144. In addition to rehearings and appeals, involuntary patients and relatives or friends of these patients may challenge the legality of retention by petitions for a writ of habeas corpus. Habeas corpus relief, however, is rarely sought.

area.<sup>145</sup>

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 care facility. Hospitals in New York need not accept all patients presented for admission. As a practical matter, however, Manhattan Psychiatric Center, the primary long-term care public facility serving the First Judicial Department, admits all involuntary transferees unless the transfer papers are not properly completed.

Voluntary transferees who do not wish to be admitted to Manhattan Psychiatric Center will not be accepted there, however. Typically, in this situation, Center personnel telephone the sending institution and inquire whether it wishes the patient returned. Frequently, these patients are discharged. Some patients, aware of this practice, convert to voluntary status prior to transfer intending to refuse admission to Manhattan Psychiatric Center. Of course, many such patients are returned to the sending facility, where two-physician certification proceedings may be instituted to convert the patient's status to involuntary. Staff at Metropolitan Hospital, in an effort to prevent voluntary patients from refusing admission at the facility to which they are transferred, frequently convert voluntary patients to involuntary status prior to transfer.

The New York statutes forbid patient transfer to another hospital by any form of involuntary admission without notice to the MHIS.<sup>146</sup> The MHIS receives copies of all transfer notices and attempts to meet with all patients who are to be transferred. Because transfer typically results in movement of the patient to a longer-term, less desirable state hospital, MHIS attorneys frequently request hearings to contest transfer. Although transfers need not be approved by the MHIS, the notification process enables the MHIS to represent patients who wish to contest transfer to a more restrictive facility.

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145. Bellevue physicians, however, question whether they have the authority to order such transfers, since at the time of the transfer the individual has no patient status at Bellevue.

146. N.Y. MENTAL HYG. LAW § 9.27(f) (McKinney 1978).

### C. *Patients' Civil and Personal Rights*

The New York statute provides 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."<sup>147</sup> The following are additional statutory requirements:

1. careful reexamination and evaluation of each patient not less than once a year.

2. medical and dental evaluations and evaluations of mental disabilities of inpatients by qualified professionals no less frequently than once a year.

3. the order of a staff member operating within the scope of a professional license for any treatment or therapy based on appropriate examination.

4. consent for surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures.

5. 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.<sup>148</sup>

The statute also protects the personal and civil rights of patients, including the rights to vote and to conduct personal and business affairs.<sup>149</sup>

A patient who refuses routine treatment during a period of hospitalization may appeal any treatment order through an administrative appeals route but ultimately may be ordered to submit to treatment.<sup>150</sup> The following procedures are used when an involuntary patient objects to treatment other than extraordinary treatment:

- (1) The objection and the doctor's request to treat will be reviewed by the head of the service. The result of that review is sent to the patient, the patient's representative, and the MHIS.

- (2) The patient or his representative may appeal to the di-

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147. *Id.* § 33.03.

148. *Id.*

149. *Id.* §§ 33.01, 29.03.

150. *See* N.Y. ADMIN. CODE tit. 14, §§ 27.8, 27.9 (1977).



rector of the facility. The director will make a decision and 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.<sup>151</sup>

In the case of extraordinary treatment, such as electroshock therapy or surgery, no treatment may be forced without a court determination that the patient is incompetent to consent. If the psychiatric staff of a Health and Hospitals Corporation facility question a patient's capacity to give or withhold consent, they may contact the Office of General Counsel which, in turn, seeks to obtain court authorization for the extraordinary treatment.

Although most observers in New York agree that patients should not be treated during the appeals process, unless treatment is necessary to preserve the safety of the patient or others, many admit that some physicians treat patients 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 stay. Legal commentators suggest, however, that this permission to treat should expire after a reasonable period of time.<sup>152</sup>

Observers in New York City disagree regarding the extent to which the civil and personal rights of patients are protected in the local hospitals. Some contend that conditions are often unsanitary, that heating in the winter is frequently inadequate, that basic medical care often is not provided, and that the personal safety of patients is not well protected. Some 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.<sup>153</sup>

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151. N.Y. ADMIN. CODE tit. 14, § 27.8 (1977).

152. See, e.g., Zlotnick, *First Do No Harm: Least Restrictive Alternative Analysis and the Right of Mental Patients to Refuse Treatment*, 83 W. VA. L. REV. 375, 435 n. 237 (1981).

153. The authors have little firsthand knowledge of conditions in the local hospitals and, therefore, are unable to offer an assessment.

#### D. *Discharge and Conditional Release*

The statute permits the hospital to discharge or conditionally release an involuntary patient if he or she "does not require active in-patient care and treatment."<sup>154</sup> The patient may be conditionally released, rather than discharged, if his clinical needs warrant this more restrictive placement.<sup>155</sup> Following a conditional release, if the director determines that the patient needs inpatient treatment and care and that the release is no longer appropriate, the director may at any time terminate the release and order the patient to return to the facility.<sup>156</sup>

The conditional release provisions provide the hospital an opportunity to release a suitable patient to a less restrictive placement while retaining the authority to supervise the patient and to bring the patient back into the hospital if the community placement is ineffective or if the patient fails to participate in the treatment program. The conditional release status is not used at acute care hospitals in New York City, such as Bellevue Hospital, and is rarely used at long-term care facilities, such as Manhattan Psychiatric Center. The primary reason is, once again, lack of available resources. Hospital staff contend that there are insufficient alternative facilities or programs and insufficient personnel to follow-up with released patients to monitor their progress. Thus, the hospital must either simply discharge or retain the patient. Another reason is that, because hospitals have no mechanism to control potentially dangerous patients on release status, they fear third-party liability.

Since the conditional release provisions were added to the Mental Health Act in 1975, only about thirty patients at Manhattan Psychiatric Center have been placed on that status. Because of the resource limitations discussed above, the hospital reportedly has not followed statutorily required monitoring procedures.<sup>157</sup>

According to one MHIS attorney, at any given time at least six or seven patients ready for discharge or release are held at Manhattan Psychiatric Center because they have no place to go.

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154. N.Y. MENTAL HYG. LAW § 29.15(a) (McKinney 1978).

155. *Id.* § 29.15(b). The release must be in accordance with a written services plan.

156. *Id.* § 29.15(e).

157. *See* N.Y. MENTAL HYG. LAW § 29.15(f) (McKinney Supp. 1983-1984).

Some of these patients wait as long as six months to a year for alternative placement. This situation resulted in the filing of *Johanne S. v. Carey* discussed earlier.<sup>158</sup>

## VII. Conclusion

Civil commitment laws provide merely the skeleton of civil commitment systems. The vital functions are better represented by the practices, customs, and mores of the people who are responsible for implementing these laws in the community. Civil commitment reform that fails to take into account the entire system is of limited value.

This Article has focused on the everyday workings of the civil commitment system in New York City. It has examined in some detail the means employed in the City to implement the state's commitment laws and has presented a practical analysis of what works well and what does not. By focusing on these successes and failures, policy makers in New York have an excellent opportunity to effect meaningful reform in their city's civil commitment system.

## APPENDIX\*

### STUDY METHODS

The study upon which this article is based is one of six studies of involuntary civil commitment systems undertaken in various parts of the country by the Institute on Mental Disability and the Law. This Appendix describes the general study methods that the research staff employed to acquire the information in New York City as well as the other five study sites.

#### A. Literature Review

Beginning in January, 1981, the staff of the Involuntary Civil Commitment Project reviewed professional literature on the topic of mental health law, with emphasis on allegedly men-

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158. See *supra* notes 59-66 and accompanying text.

\* This description of the study methods used in this study appeared in substantially the same form as part of Keilitz, Fitch & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. U.L. Rev. 238, 308 (1984) and is used here by permission.

tally ill adults. The initial period of review lasted approximately two months, although literature was reviewed continually throughout the project period. Source materials were collected from books and journals in the disciplines of law, psychiatry, psychology, social work, sociology, and public policy administration. University professors and mental health professionals were informed about the project and asked to provide copies of unpublished papers or other hard-to-find articles that would be of value to the project.

Prior to the meeting of the project's national advisory board in April, 1981, staff members prepared an "issues paper" summarizing the relevant literature and defining the important contemporary issues of civil commitment with which this project was to be concerned (the substantive portions of this paper have been previously published.)\*\* At the meeting, members of the board helped the staff decide what research questions should be explored during field research and gave advice on field research methods.

### B. *Statutory Review*

A scheme was devised for analyzing statutes governing civil commitment. The scheme was constructed by identifying all the important questions that might be addressed in a commitment statute and then ordering them roughly as they might become relevant in a typical case.

A complete statutory analysis was performed for approximately twenty states, as well as for the model statute prepared by the Mental Health Law Project (published in the July-August 1977 issue of the *Mental Disability Law Reporter*). The twenty states were those in which the project had received funding, or states that had been brought to the staff's attention as having statutes that were particularly interesting, innovative, or modern.

After an individual review of all the statutes, a comparative analysis was made. Using the analytical scheme that had been developed, staff compiled all the variations of statutory provi-

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\*\* See Zimmerman & Fitch, *Involuntary Civil Commitment: The Discerning Eye of the Law*, 5 St. Ct. J. 5 (1981).

sions relating to each of the analytical categories. This compilation of statutory variations formed the basis for the major product of the first phase of the project. Based upon this analysis, staff determined where and how state statutes and procedures differed with regard to civil commitment. These points of difference became the focus for field data collection.

In addition to reviewing statutes, the staff reviewed important case law. The *Mental Disability Law Reporter*, law review articles, and statute annotations were the major sources for identifying important cases. When the case law significantly added to or changed the range of variation that had been identified through the statutory analysis, this information was incorporated in the comparative analysis. Particularly thorough analyses of case law were conducted for six states: California, Illinois, Ohio, New York, North Carolina, and Wisconsin.

The project staff also contacted court administrators across the country to obtain any type of administrative regulation that might be of help. Several copies of regulations were received. For all states whose statutes were analyzed, published court rules were also examined. Information gleaned from administrative regulations and court rules was sparse, but it also was included in the statutory analysis when appropriate.

### C. *Preliminary Site Visit*

A preliminary visit was made to five of the six project sites. Staff members met with judges, court personnel, attorneys, and mental health professionals. The preliminary visit served several purposes. First, the participants in the civil commitment systems gave staff members their perceptions of how the systems worked. Cooperation was pledged for the research project. Staff of the courts and the mental health agencies invited the research team to include them in the data collection effort and generously offered their help.

The individuals with whom we met during the preliminary site visit identified the agencies and institutions in New York City that were involved with the mentally ill and civil commitment. Key people within these organizations were named, and others who were unrelated to major institutions, but who were deemed important or knowledgeable in a particular area, were identified.

#### D. *Site Visits*

Intensive data-collection trips to each of the six funded sites followed the completion of the comparative statutory analysis. The authors worked in New York City in late 1981 and mid-1983.

During the two weeks prior to the site visits, intensive preparations were made. Important people at the site, who had been identified during the preliminary site visit, were contacted by telephone and appointments were made for visits the next week. The staff thoroughly reviewed the New York statutes and case law and identified questions of particular theoretical or practical concern for the New York City system.

Three major activities were undertaken during site visits: interviews, observations, and staff discussions. Most participants were interviewed individually, although some were interviewed in groups. With few exceptions, all interviews were conducted by two of the authors. While one attended carefully to substance and led the interview, the other recorded all the answers. In this manner, one person could attend carefully to what was being said and be sure to investigate thoroughly all important questions, and the other could be sure that everything that was said was carefully recorded. The site visit began with interviews with judges and observations of hearings. Then attorneys, public defenders, deputy district attorneys, and private attorneys were interviewed. Later interviews tended to focus more on the mental health community: hospital administrators, mental health professionals, and patient advocates.

Court hearings conducted during the time of the visit were observed. For each site, an observation guide was prepared and studied in advance of the hearings. The project team took notes in rough form during the hearings, then rewrote the notes during the week following the site visit.

The third major activity — discussion and analysis — took place at the end of each day when the staff met to compare notes and impressions about the system. Key concerns were (1) which answers from various sources agreed with each other; (2) which answers from those sources disagreed; and (3) which answers were still missing. On the basis of these discussions, interview assignments for the next day were planned. When staff members were confident of the answers they had re-

ceived, no further questions were asked on certain topics. When they were uncertain, additional attention was given to these questions in the next interviews.

The people with whom interviews were conducted were not a statistically representative sample in any sense. They were purposively chosen because they were identified as some of the most well-informed and influential people in New York City with regard to civil commitment. This was consistent with the project goal; that is, to gain insight into how the system works and how it might be made better by the actions of the court and its allied agencies, from the perspectives of people with extraordinary and authoritative abilities to understand and comment on it.

Of course, the purposive sampling of interviewees within a perspective favoring court action (as opposed to the perspective of a public defender, civil libertarian, or involuntary commitment "abolitionist," for example) may have left some perspectives under-represented. Although we did interview ex-patients and patient advocates, we did not speak with patients involuntarily hospitalized at the time of our study. We acknowledge that the perspective of the involuntarily hospitalized persons may be one quite different from that of ex-patients and advocates to whom we spoke at the various sites, and one potentially valuable for improvement of the system (even from our perspective of court action). The close observation of several cases through the various stages of the commitment process, enriched by the accounts of the patients themselves, is a particularly attractive inquiry which we were unable to reach. Such omissions do not make the present work less valid, but only incomplete — an unfortunate flaw of most social research.

#### E. *The Form of the Data*

The ultimate goal of the project was to generate information by which the civil commitment process could be made to function as well as possible. 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, not quantitative. We sought information about what works best and why.

The questions in the data collection guide were open-ended. Multiple-choice questions 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 consisted of a complete set of all the questions that were investigated: it covered many topics. The complete data collection flowed in a more-or-less chronological order, as events occurred during a typical commitment process. The questions unavoidably overlapped to some degree, but repetition was minimized as much as possible.

Because of the length of the data collection guide, every question was not asked at every interview. A subset of questions was presented in each interview to optimize the match of peoples' areas of knowledge with the questions asked. All interviewees were invited, however, to discuss any aspect of the commitment process with which they were familiar or about which they had particular opinions or suggestions. Interviewers were able to (and frequently did) stray from the planned path of questions if it seemed useful and appropriate.

The questionnaire was considered only a data collection *guide*, not a dictum. Precise language in the questions was not considered important, and neither was the order in which the questions were covered. The guide was simply a reminder of important issues and ideas that needed to be discussed. More concern was given to understanding the answers than to writing them down thoroughly or verbatim.

#### F. *Analysis, Report and Review*

A qualitative content analysis was performed on the data. Interview and observation notes first were reviewed and cross-referenced. Note was made of topics of significance, points of consistent agreement, and points of disagreement.

The statutory analysis scheme was used as a general guide for the analysis of the particular site's civil commitment system. For each topic of concern, the analysis covered the statutory provisions, the actual practice at the site, and commentary about statute and practice.

Three major criteria, consistent with the project's perspective, were used to evaluate the civil commitment system de-



scribed in this Article: legal protections, provision for treatment, and social benefits. 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, their observations, their discussions with practitioners, and (as our sociologist colleagues are quick to point out) their socio-historic biographies. The reader is free, of course, to disagree with this analysis and may choose to view the system's strengths and weaknesses differently. A system characteristic may be simultaneously a strength and a weakness, when viewed from different perspectives.

First, concern was given to the extent to which legal protections are provided to everyone in the system. The primary consideration was, of course, with the involuntarily detained patient. But statutes and procedures also can provide important legal protections to other people who become involved, such as doctors, attorneys, and members of the patient's family. Generally, this is an important criterion for those who are most concerned about the patient's liberty; but legal protections encompass more than simply protecting a person from unnecessary hospitalization (for example, protecting the right to treatment).

The analysis also considered how well a system makes provisions for treatment. Admittedly, we are assuming that a valid need for treatment does exist for some people some of the time — an assumption consistent with the public values reflected in current commitment laws throughout the country. Provisions for treatment should be understood to encompass more than involuntary hospitalization; however, a system might get high marks in this regard by its creative consideration of less restrictive treatment alternatives and the opportunities for voluntary treatment that it provides.

Finally, social benefits, including fiscal factors, were considered. Society in general has a legitimate concern with keeping each of its members safe from harm and contributing productively to the community. Society is also served by minimizing the costs inherent in a civil commitment system, eliminating any unnecessary delays in legal and medical decisionmaking, and avoiding undue burdens on already strained state resources.

These factors are considered equally important in this Article, and it is recognized that some system characteristics that score high in one area necessarily will score low in another. It

should be noted, too, that we make no claim that this evaluative scheme is either unique or original. Professional literature reveals that these criteria are used commonly in considering commitment systems, as well as by judges in deciding individual commitment cases. The courts are accustomed to the balancing interests (that are sometimes conflicting) as an approach to analyzing legal problems.

To complete the analysis, possible ways to change and improve the system were considered. These were written into various recommendations throughout this Article. The recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are our suggestions, based upon our studies and points of view. The recommendations derive from a variety of sources: suggestions made by people at the sites, conclusions from the professional literature, and ideas generated by the authors during the project work. It is impossible to sort out the influence of these various sources in any recommendation, or to report accurately how extensively any person or group would agree with any single recommendation.

The purpose of presenting recommendations is to highlight certain problems and alert people in New York City to possible solutions. Although it is easy for us to identify a problem, we do not pretend to hold "The Answer." A more realistic expectation is to present "an answer," however modest and tentative, as a stimulus and starting point for thoughtful consideration by those who know the system in New York City better and are in a position to make appropriate changes.

Site reports were reviewed first by project staff and then sent out as "review drafts." The report upon which this Article is based was sent for review by all individuals who had participated in the data collection effort. Everyone receiving a review draft was invited to make suggestions for change and was urged to correct any statements that were factually incorrect.

These reviews were then taken into account in preparing the final report from which this Article was adapted. It should not be inferred, however, that this Article or its recommendations have been or will be adopted officially by any individual, group, or organization in New York City, or that the reviewers and participants had a unanimous concurrence of opinion on all issues raised in this Article.