The Law of Guardianship and Involuntary Admissions After Kendra's Law

By Bruce M. DiCicco

Article 9 of the New York Mental Hygiene Law (MHL) is a statute designed to assist the mentally ill while balancing the constitutional right to freedom. But is the legal threshold imposed by statute properly balancing the needs of the mentally ill who would benefit from treatment when the period of restricted liberty is expressed in just hours or a few days? This article will look at an all-too-common scenario and consider the impact of Kendra's Law on the matter.

HYPOTHETICAL

Your client's brother earned straight As in school and went to an Ivy League college, graduating with high honors, while also getting high frequently. The brother had amazing powers of concentration that allowed him to study days on end with little or no sleep. He got a high-paying job and was off on a career in business after graduation. As life progressed you and your family noticed his behavior becoming unusual. He left his job in order to write a book about "the universe and alien influences." It was 800 pages and consumed all his time for a year. He began having outbursts about inconsequential things.

Bruce M. DiCicco has practiced law for over 38 years having first been admitted to the Bar in North Carolina, August of 1979, New York 1986 and New Jersey 1987. He has authored numerous articles on the subject of trusts, estates and estate planning and holds a Masters of Law degree in Federal Taxation (LL.M. – Tax). He is the recipient of the Empire State Counsel Award from the New York State Bar Association for 50 or more hours of service to the poor in 2006 and in 2009 as well as the Certificate of Appreciation for Public Service on Behalf of the Administration of Justice, the Protection of Law Clients and the Integrity of the Profession from the Lawyers Fund for Client Protection. More information is at DiCiccolaw.com.

He developed beliefs about people trying to harm him and spying on him that seemed delusional. He stopped working and was supported by contributions of family members who responded to urgent pleas for financial assistance or else terrible things would happen of one sort or another. He became severely withdrawn and reclusive.

Visits to a psychiatrist reveal a diagnosis of bipolar disorder with paranoid features. He has responded to encouragement from family members and anti-psychotic medicine, which brings him out of his manic and pre-manic states within a day or two if it has not gone too far or gotten too deep. Left untreated, long-term periods of mania take much longer to correct. After treatment and counseling that helps readjust brain chemical levels, he returns to work, as jobs are easy to come by with his educational background and high intelligence. After treatment he realizes he was manic and is grateful to be back in the normal flow of life. But then alcohol and/or drug use (not necessarily in that order) or stress brings on the manic cycle anew. You recognize the symptoms. This time you want to get ahead of the curve so you call Adult Protective Services Program (APS), which provides services for physically and/or mentally impaired adults in New York. The agency works to help at-risk clients live safely in their homes, but your client's brother refuses them access to his apartment and does not respond to any offers from friends or family to assist. His psychiatrist will attest to the fact that he suffers from mental illness and his condition is deteriorating again, but since he has not come to appointments for several months the psychiatrist is reluctant to give an opinion on whether he is in any present danger.

The concern for his well-being and the manic behavior moves you to have an old family friend knock on his door. The brother allows access. The friend views the substantial destruction and disassembly of the apart-

ment. Appliances have been stripped down and taken apart, electrical outlets have been removed from the walls, exposing bare wires, and large sections of the wooden flooring is torn up and placed into a huge pile inside the apartment with the nails exposed. When asked about this, the brother says he is looking for spies and aliens that he knows are there and who are listening to him. You do not know whether bills have gone unpaid or the status of his physical or nutritional health, but you do know that things have reached a critical juncture and are headed downward again. He refuses any medical intervention, saying he has "super powers" that will protect him from all things. What to do?

GUARDIANSHIP

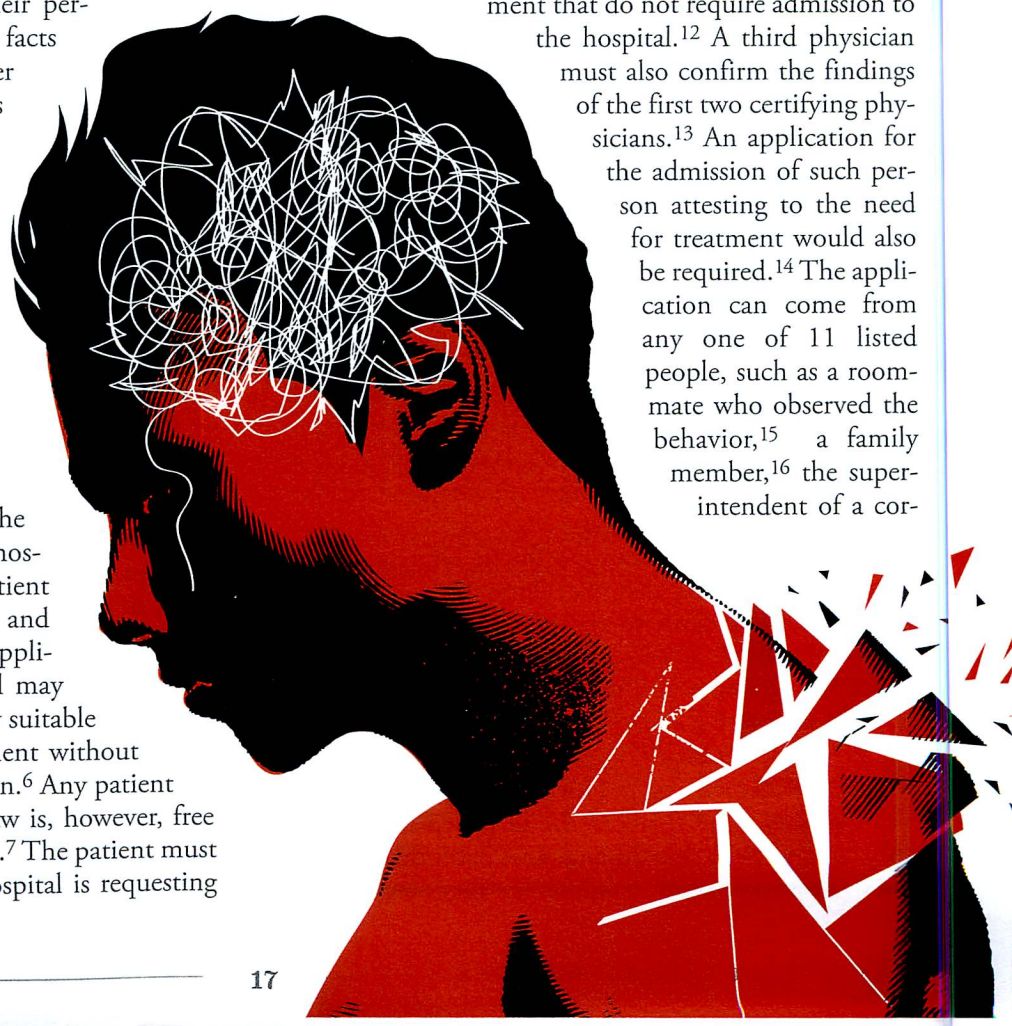
New York State law allows for the appointment of guardians for incapacitated persons. Mental Hygiene Law Article 81 requires a petitioner to meet the highest standard of proof in civil cases, which is the "clear and convincing evidence" standard.[1] The petitioner in a guardianship case must satisfy the court that the evidence makes it highly probable that what the petitioner claims is actually what happened.[2] The evidence required for a personal needs guardian requires a showing of deficiencies in attending to the activities of daily life, including "procurement of food, clothing, arranging for or maintaining shelter, coordinating health care or the inability of the individual to understand and appreciate the risk inherent in their behavior to their personal safety."[3] It is unlikely, given the facts of the hypothetical, that the brother will make statements elucidating his superhuman powers that a court could find would cause him harm. It is also the case that he cannot be made to testify in an Article 81 proceeding.[4] Petitioners will need a better approach under the circumstances of the hypothetical to get care for the subject.

MENTAL HEALTH VOLUNTARY COMMITMENT

Article 9 of the MHL comes to the rescue, or does it? A director of any hospital may receive as a voluntary patient any suitable person in need of care and treatment and who makes a written application.[5] The director of any hospital may also receive as an informal patient any suitable person who requests care and treatment without making a formal or written application.[6] Any patient admitted under this section of the law is, however, free to leave any time after being admitted.[7] The patient must also be made fully aware that the hospital is requesting that he or she be admitted as mentally ill, that he or she is making an application for that admission and the nature of the voluntary or informal status governing his or her release or a conversion to involuntary admission status.[8] Typically, people like the brother in the hypothetical will not even let family members into their apartments, so there is no way of getting them to take a ride down to Bellevue and, even if they did, once they realized it was a hospital, they would very likely just walk out.

MENTAL HEALTH INVOLUNTARY COMMITMENT AFTER PRESENTMENT

The provisions for involuntary admissions are the next consideration. A director of a hospital may petition under MHL § 9.27 to receive a mental patient. This typically arises on an arrest of some sort, even for a minor criminal offense, where the police present the person to the hospital. In fact, state and local officers have a duty to encourage mentally ill persons to apply for admission as a voluntary or informal patient.[9] Two psychiatrists could then certify the need for treatment under the controlling standard, which is the existence of a mental illness for which involuntary care and treatment is required.[10] The standard for required treatment is not spelled out in the statute but it has been held to be evidence that the patient poses a substantial threat of physical harm to himself and/or others.[11] The doctors are also required to consider alternative forms of care and treatment that do not require admission to the hospital.[12] A third physician must also confirm the findings of the first two certifying physicians.[13] An application for the admission of such person attesting to the need for treatment would also be required.[14] The application can come from any one of 11 listed people, such as a roommate who observed the behavior,[15] a family member,[16] the superintendent of a cor-



rectional facility,[17] other directors of facilities treating the mentally ill,[18] or a treating psychiatrist who sees the patient in a mental illness facility.[19] The certificates from the physicians must be executed within 10 days of the admission.[20] Family members are typically more than willing to make the application. Section 9.39 of the MHL also provides for emergency admissions for immediate observation, care and treatment. Ah, but how to get the brother in our hypothetical to be politely arrested or present before hospital personnel?[21] This is unlikely to happen given the facts of the scenario. Next idea.

MENTAL HEALTH WARRANT OF COMMITMENT AND EMERGENCY TREATMENT

The law allows one to bring a petition seeking a Warrant of Commitment supported by a verified statement. The statement must show that a person is apparently mentally ill and is conducting himself or herself in a manner that would only be disorderly conduct of a person who is not mentally ill, or that the person is conducting himself in a way that is likely to result in serious harm to himself.[22] The statute allows the court to direct the person be brought before the court (by the Sheriff's Department in handcuffs is typically how this is accomplished) for a hearing after which the person may be ordered to a hospital or comprehensive psychiatric emergency program for evaluation as to whether the person should be retained. If ordered to a hospital, MHL § 9.39 applies, and if to the program, MHL § 9.40 applies. Both spell out detailed procedures and safeguards for the patient. MHL § 9.40 dictates emergency observation for a period not to exceed *72 hours* upon a referral made by the court. The evaluation must take place "as soon as practicable" but within *six hours* of being received into the emergency room.[23] MHL § 9.39 directs retention for no more than *48 hours* after admission upon finding that the person meets the standard for emergency admission, and that finding must be confirmed by a second physician within that time. This sounds promising to get help to our hypothetical brother.

STANDARD APPLIED BY THE COURTS TO COMMIT

The court must find, however, for the aforesaid involuntary commitments that the illness is ". . . likely to result in serious harm to the person or others."[24] Or the likelihood of serious physical harm as manifested by suicide attempts or threats of suicide or homicidal or other violent behavior.[25] But the brother really does not fit in these categories just yet and herein lies the problem. Well-meaning and loving family members face well-ingrained legal rights of the ill patients, but is the protection of these rights doing more harm than good? It is also a principle of the common law that every adult of sound mind has a right to determine what shall be done with his or her own body and to control the course of his or her own medical treatment.[26] Precedent has declared that such rights may be set aside only in narrow circumstances, including those where the patient "presents a danger to himself or other members of society or engages in dangerous or potentially destructive conduct within the institution."[27]

Courts have looked to a variety of factors in evaluating harm. Where a party's ability to comprehend her illness and need for treatment is impaired, an involuntary admission for psychiatric treatment is appropriate.[28] Courts have ruled that a showing of recent suicidal or homicidal conduct is not necessary for an involuntary admission. *Rueda v. Scharmine*, *supra* [holding that disrobing in public could constitute conduct demonstrating that a person is a dangerous risk to herself under MHL § 9.39, establishing a substantial risk of physical harm]. This is not the only hurdle, though, in involuntary cases because medication is also typically needed, as in the hypothetical case under discussion here.

The law was designed to address situations of mental illness before violence occurred by allowing petitions which may result in court-ordered treatment for mental illness.

Assuming the harm standard is met, it has been held that an order directing involuntary psychiatric treatment is only appropriate where the patient is unable to appreciate his or her illness.[29] Courts have recognized the power of the state to order involuntary treatment under the doctrine of *parens patriae*.[30]

The seminal Supreme Court pronouncement driving the foregoing case law is that the State may not confine a non-dangerous individual who is capable of surviving safely in freedom by himself or herself or with the help of willing and responsible family members or friends. In *O'Connor v. Donaldson*, the patient had been confined for nearly 15 years while continuously demanding his release from a Florida mental institution.[31] The patient posed no danger to others or to himself during the time he had been confined, and he also showed that his requests for release had been supported by responsible persons willing to provide any care he might need on release. *O'Connor* was a terribly egregious set of facts. Is the application

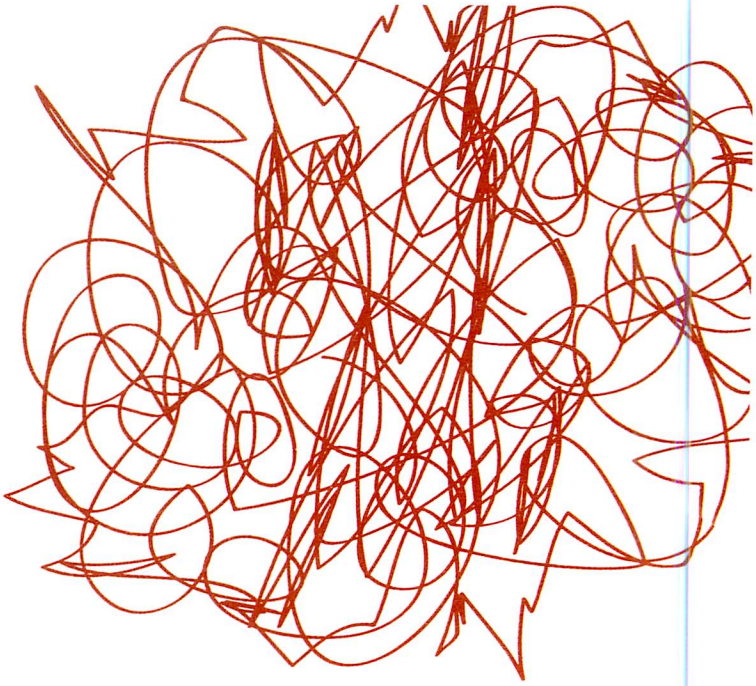
of the same standard wisely applied to limited loss of freedom as provided for in Article 9 and does such an application help the mentally ill individual by preventing evaluation and treatment?

KENDRA'S LAW

New York State has reacted to violent incidents involving mentally ill persons who were not effectively treated by enacting MHL § 9.60, designated as "Kendra's Law." The statute was named after Kendra Webdale, who was pushed to her death into a subway train in New York City by a mentally ill person. The law was designed to address situations of mental illness before violence occurred by allowing petitions which may result in court-ordered treatment for mental illness. In New York State one may, in addition to the previously discussed remedies, petition the court to require compliance with an assisted outpatient treatment program of persons over age 18 who are suffering from mental illness and who are unlikely to survive safely in the community without supervision, based on a clinical determination and other factors. The programs are known as AOTs. In order to petition, one must meet certain other criteria designed to identify persons with a history of mental illness.[32] The law is not permanent but rather scheduled to expire on June 30, 2022. A history of mental illness is defined as either:

> (i) twice within the 36 months prior to the petition mental illness has been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or
>
> one or more acts of serious violent behavior toward self or others or threats of or attempts at, serious physical harm to self or others within the last 48 months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated.[33]

Also required is a finding that as a result of the mental illness the person is unlikely to voluntarily participate in outpatient treatment that would enable the person to live safely in the community.[34] It is further required that the person must need assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in serious harm to the person or others, and the person will likely benefit from the assisted outpatient treatment.[35] As can be surmised, extensive medical testimony is likely required to establish these factors. In our hypothetical they are unlikely to be accomplished due to the condition and characteristics of the patient. Petitions under Kendra's Law can only be brought by the following persons:



(i) a person 18 years of age or older with whom the subject of the petition resides; or

(ii) the parent, spouse, sibling 18 years of age or older, or child 18 years of age or older of the subject of the petition; or

(iii) the director of a hospital in which the subject of the petition is hospitalized; or

(iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition or in whose institution the subject of the petition reside; or

(v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for mental illness; or

(vi) a psychologist, licensed pursuant to Education Law §153, or a social worker, licensed pursuant to Education Law Article 154, who is treating the subject of the petition for a mental illness; or

(vii) the director of the community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or

(viii) a parole officer or probation officer assigned to supervise the subject of the petition.[36]

Numerous constitutional safeguards are included in Kendra's Law, such as notice of the petition under this section to all persons listed in MHL § 9.29, the mental hygiene legal service, the health care agent if any such agent is known, the appropriate program coordinator, and the appropriate director of community service. The petition must be accompanied by an affirmation or affidavit of a physician who shall not be the petitioner stating that the physician has personally examined the subject of the

petition and that the subject of the petition is uncooperative.[37] The subject of the petition has a right to be represented by the mental hygiene legal service or privately financed counsel, at all stages of the proceeding.[38] A hearing on the petition shall be no later than three days from the date such petition is received by the court, excluding Saturday Sundays and holidays. Adjournments shall be permitted only for good cause.[39]

Numerous constitutional safeguards are included in Kendra's Law.

CONCLUSION

In our hypothetical, there has been no electrocution from the exposed wires and no puncture wounds from the demolished flooring, *yet*. As pointed out, the courts will balance the loss of liberty versus harm. Under the hypothetical facts, a petitioner will likely lose without more physical harm or threats of harm to self or others. But where is the superpower belief headed? Will a person having such beliefs step into the road believing he can stop an oncoming truck? Where is the hypothetical life of the brother headed if untreated mania continues unabated? Untreated bipolar disorder is a serious health risk because the longer it goes on the worse it becomes.[40]

Kendra's Law will likely not apply in our hypothetical due to the lack of mental illness history. It seems, therefore, that while society should be very cautious in denying one's liberty, treatment for very short periods of time as set forth in Article 9 of the New York statute, not the tragic 15 years reviewed in the seminal case of *O'Connor*, *supra*, might be more liberally construed so as to get help to the mentally ill before violence and harm emerge and before treatment becomes more difficult. The *O'Connor* standard, while appropriate in that case and others like it, is often being applied in the experience of this author in an overly restrictive manner to Article 9 limited evaluation/limited loss of liberty situations. This reluctance by the courts to consider consistent and demonstrated delusional beliefs as harmful in turn may defeat the purpose of Kendra's Law by not allowing documentation of the needed history of mental illness to trigger the AOT assistance that was intended to be given to our mentally ill population that does not involve confinement and the attendant loss of liberty.

1. MHL § 81.02 (b); 81.12 (a). See *In re Rosalie D.T.*, Case No. 32361-1-2017, 2017 N.Y. Misc. LEXIS 5095 (Nassau Co. Ct. Jan. 8, 2018), citing *In re Samuel S. (Helene S.)*, 96 A.D. 3d 954, 957 (2d Dep't 2012); *In re Maher*, 207 A.D.2d 133, 139–40 (2d Dep't 1994)).

2. Prince, Richardson on Evidence, § 3-205 (ed.); 1 *NY Pattern Jury Instructions* 2d. (Supp.), P.J.I. 1:64).

3. Russo & Machlin, *New York Elder Law & Special Needs Practice*, §8.3 (2017 ed.).

4. *In re Eugenia M.*, 20 Misc. 3d 1110(A) (Sup. Ct., Kings Co. 2008); *In re United Health Services Hospitals, Inc.*, 6 Misc. 3d 447 (Sup. Ct., Broome Co. 2004).

5. MHL § 9.13.

6. MHL § 9.15.

7. *Id.*

8. MHL § 9.17.

9. MHL § 9.21 (a).

10. MHL § 9.27(a).

11. *Rueda v. Charmaine D.*, 76 A.D. 3d 443 (1st Dep't 2010).

12. MHL § 9.27(d).

13. MHL § 9.27(e).

14. MHL § 9.27(b).

15. MHL § 9.27(b)(1).

16. MHL § 9.27(b)(2).

17. MHL § 9.27(b)(3).

18. MHL § 9.27(b)(3–11).

19. MHL § 9.27(b)(11).

20. MHL § 9.27(b).

21. This article does not include a discussion of the rights of a defendant who, as a result of mental disease or defect, lacks capacity to understand the proceedings against him or to assist in his or her own defense and therefore cannot be prosecuted for a criminal offense. CPL § 730.20; see, for example, *Ending Disparities and Achieving Justice for Individuals With Mental Disabilities*, 80 Albany Law Review 1037 (2016). Nor does it discuss matters over which the family court has jurisdiction to order the psychiatric examination of a child. Family Court Act § 251 (a).

22. MHL § 9.43(a).

23. MHL § 9.40(b).

24. MHL § 9.40(a).

25. MHL § 9.39(a)(1) & (2).

26. *Rivers v. Katz*, 67 N.Y.2d 485, 492 (1986).

27. *Id.* at 495.

28. *Anonymous v. Carmichael*, 284 A.D.2d 182, 727 N.Y.S. 2d 408 (1st Dep't 2001) (where involuntary admission under MHL § 9.33 was directed because the patient was, "unable to understand the need for such care and treatment," had threatened his family with a weapon and demonstrated aggressive behavior). *Consilvio v. Diana W.*, 269 A.D.2d 310, 703 N.Y.S. 2d 144 (1st Dep't 2000) (where under MHL § 9.33 involuntary admission was ordered because the patient, ". . . does not understand the need for care and treatment," failed to treat her fractured ankle and lacked proper nutrition).

29. *Jay S. v. Barber*, 118 A.D.3d 803, 988 N.Y.S. 2d 68 (2d Dep't 2014) (directing the administration of medication).

30. *In re Sawyer*, 68 A.D. 3d 1734, 891 N.Y.S.2d 813 (4th Dep't 2009) (directing the administration of medication where the patient does not have the ability to make a reasonable decision about her medical condition); *In re McConnell*, 147 A.D.2d 881, 538 N.Y.S. 2d 101 (3d Dep't 1989) (directing involuntary psychiatric treatment where the patient is unable to appreciate her illness and cannot make a reasonable decision concerning appropriate treatment); *N.Y.C. Health & Hosps. Corp. v. Brian H.*, 51 A.D.3d 412, 415, 857 N.Y.S. 2d 530 (1st Dep't 2008) (where AIP failed to seek medical treatment after a fireworks device blew up in his hands, requiring amputation).

31. 422 U.S. 563, 576 (1975).

32. MHL § 9.60(a)(1) & (c).

33. MHL §9.60(c)(4)(i) & (ii).

34. MHL § 9.60(c)(5).

35. MHL § 9.60(c)(6) & (7).

36. MHL § 9.60(e).

37. MHL § 9.60(e)(3).

38. MHL § 9.60(g).

39. MHL § 9.60 (h).

40. See, for example, https://healthguides.healthgrades.com/finding-the-right-bipolar-treatment/the-dangers-of-untreated-bipolar-disorder.