

The Mental Hygiene Legal Service at 50: A Retrospective and Prospective Examination of Advocacy for People with Mental Disabilities

By Sheila Shea

The year 2014 will mark the fiftieth anniversary of the establishment of the Mental Health Information Service (MHIS),¹ which in 1986 became the Mental Hygiene Legal Service.² Upon its creation in 1964, the Service was a “novel experiment” to protect and ensure the rights of patients in psychiatric facilities.³



Following its establishment, one commentator observed that the Service represented “history’s first genuine legislative concern with providing *effective* legal safeguards for persons sought to be committed to psychiatric hospitals”⁴ (emphasis in original). Almost fifty years later, the Service’s basic core function—to study and review the admission and retention of all patients and residents—remains unchanged.⁵ Over time, however, the mandate of the Service significantly expanded in response to case law and legislative enactments.⁶

The Service now operates as a dedicated legal advocacy program providing a broad range of protective legal services and assistance to individuals with mental disabilities not only in psychiatric hospitals, but any facility where services for mentally disabled individuals are rendered.⁷ MHLS constituents include mentally ill and developmentally disabled individuals, persons alleged to be incapacitated and in need of the appointment of guardians, incapacitated criminal defendants and those acquitted of crimes by reason of mental disease or defect, and sex offenders alleged to be in need of civil management. This article explores the origins of the Service, the scope of its current responsibilities and a prospective examination of the challenges ahead.

I. The Past

Few mental patients read the Bill of Rights. The immediate problems which they are unable to bear seem remote from the honored stricture: “No person...shall be...deprived of life, liberty or property without due process of law.” Yet the whole problem of admission of the mentally ill to hospitals is tied to the question of depriving a citizen of his personal liberty.

—Mental Illness and Due Process⁸

The creation of MHIS was the centerpiece of efforts to reform commitment procedures for mentally ill persons in New York State. The tentative beginnings of that effort came in 1959 when the then Commissioner of the New York State Department of Mental Hygiene sought comments from the Presiding Justices of the Appellate Divisions concerning a legislative proposal to amend the Mental Hygiene Law. The Justices, in turn, asked for advice on the proposal from the Association of the Bar of the City of New York and the New York State Bar Association. The Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York was formed and, in cooperation with Cornell Law School, began an intensive study of New York’s civil commitment scheme.⁹

The Special Committee completed its study in January of 1962 and its findings were published in the seminal volume, *Mental Illness and Due Process*, published by Cornell University Press. Five principles served as the foundation for the special committee’s analysis of commitment procedures in New York and formed the basis for the committee’s formulation of proposed legislation. Those five principles were:

1. Every person with serious mental illness needs some care and in many cases must go to a hospital, even if he does not want to.
2. Mental hospitals are not prisons but they do, by force on body or mind, deprive the patients of some freedom.
3. Rapid, noncompulsory admission to mental hospitals is good for most patients and helps in allowing effective treatment and early release.
4. When a person must be sent to a mental hospital against his will, he should not be treated like a criminal or be tried and convicted of being sick. Procedures for his admission are only stepping stones to treatments.
5. Any person hospitalized against his will is entitled to watchful protection of his rights, because he is a citizen first and a mental patient second.¹⁰

At the time of the Special Committee’s study, New York had seven legal procedures, one voluntary and six involuntary, for admission to a psychiatric hospital. Most people alleged to be mentally ill were admitted to the hospital under section 74 of the former Mental Hygiene

Law (MHL).¹¹ By operation of section 74, an individual could be hospitalized upon the filing of the certificate of two doctors with a petition and court order committing the patient. The person could then be hospitalized for up to sixty days without any additional process. Retention of the person for an indeterminate period after the initial sixty day admission simply required the hospital director to file a certificate with the County Clerk. Upon that filing, the court order for hospitalization became final and the person could be retained for an indeterminate period until discharge.¹²

Upon examination of the practices and procedures associated with the civil commitment scheme at the time, the Special Committee made several findings, among them that:

Although the statute contemplated notice to the allegedly mentally ill person and a hearing where requested, written notice was infrequently served on the person and hearings were rarely held. The Committee observed that under statutory scheme at the time, notice could be dispensed with if it would be “ineffective or detrimental to the person” and the judge was *required* to dispense with notice if the examining physicians stated in writing that notice would be detrimental.¹³

When hearings did take place, the allegedly mentally ill person was rarely represented by counsel and determinations were based on insufficient evidence. A passage from *Mental Illness and Due Process* describes the “somber reality” of a commitment hearing from the era at Bellevue Hospital in New York City:

In the corridor outside, the patients who have requested a hearing, dressed in pajamas and hospital bathrobes, wait in a straggly gray line to present their protests against being “sent away.” A psychiatrist reads to the judge the physician’s report setting out the initial observations and recommendations of the need for care. Most patients, when called into the courtroom, talk up their “defense”; their stories are sometimes rambling and incoherent, sometimes only a pitiful pleas to go home. There is no regular representation of the patient’s rights.... The judges can and do try to explore the patient’s side of the case, but often they must make a decision on the grave issue of liberty with little more than scant evidence.¹⁴

Once a person was committed by court order, whether after a hearing or without one, the period of hospitalization was largely at the discretion of the hospital. The patient was discharged if and when the hospital director

certified that the person (a) had recovered; (b) was not mentally ill; or (c) while not recovered could be cared for at home without detriment to public welfare, or injury to the patient.¹⁵

The Special Committee recommended reform of the statutory scheme and urged adoption of a “medical model” for admission with enhanced due process protections. The Committee’s preference for the medical model of admission was derived, in part, from its observation that prompt hospitalization and immediate medical attention can be of critical importance in the treatment of mental illness and because a medical model of admission was thought to avoid the stigma of criminality which was associated with the judicial process at the time.¹⁶

To ensure that the patient’s due process rights were protected, the first recommendation of the Special Committee was that a new agency be created, independent of the Department of Mental Hygiene, to be the guardian of patient rights. That new agency, initially referred to by the Special Committee as the “Mental Health Review Service,” became the “Mental Health Information Service” (MHIS), an arm of the Judiciary, with the enactment of the Service’s original enabling statute in 1964. An MHIS was established for each of the four Appellate Division Judicial Departments and began operations in 1965.¹⁷

The original functions, powers and duties of MHIS were as follows:

1. To study and review the admission and retention of involuntary adult patients.
2. To inform such patients and in proper cases others interested in the patient’s welfare about procedures for the patient’s admission and retention and his rights to have judicial hearing and review, to be represented by legal counsel and to seek independent and medical opinion.
3. In any case before a court, to assemble and provide the court with all relevant information on the patient’s case, hospitalization and right to discharge, if any, including information from which the court may determine the need, if any, for the appointment of counsel for the patient or the obtaining of additional psychiatric opinion.
4. To perform services for voluntary patients and informal patients similar to those required under (1) and (2) as may be requested by the patient or someone on the patient’s behalf.
5. To provide such services and assistance both to patients and their families and to the courts having duties to perform relating to the mentally ill and alleged mentally ill as may be required by a judge or justice and in accordance with regulations of the Presiding Justice of the Appellate Division of each Judicial Department.¹⁸

By design, the Service was to remedy the phenomenon of the “forgotten man,” emblematic of individuals confined to back wards and “living the regular, monotonous life of the patient without hope of release.”¹⁹ The Service would ensure that when hearings were demanded, there would be an opportunity for a full presentation of the facts upon which the court would make an informed judgment.²⁰ As one commentator observed in 1971, “because of MHIS’s investigation and reporting functions, the Service may be likened to a civil commitment ombudsman.”²¹

In the ensuing years, the rights afforded to individuals committed to psychiatric hospitals were enhanced which, in turn, gave rise to a fundamental transformation of the Service from ombudsman to legal representative. The evolution of the Service into a dedicated legal advocacy organization is thoroughly discussed in a 1980 study undertaken by the Commission on Quality of Care for the Mentally Disabled [CQC] entitled, *Strengthening Patient Advocacy: A Review of the Mental Health Information Service*, authored by then CQC Chairman Clarence Sundram.²² As Mr. Sundram explained in 1980, seminal court decisions such as *Baxtrom v. Herald* (inmates whose sentences are about to expire must be accorded the same rights as civil patients),²³ *People ex rel. Rogers v. Stanley* (patients have the right to counsel in civil commitment proceedings),²⁴ and *People v. Lally* (defendants acquitted by mental disease of defect had the same rights as civil patients),²⁵ had a profound impact on the Service and the mental hygiene system as a whole. The courts’ articulation of new rights and remedies for persons subject to commitment forever changed the advocacy needs of these individuals. Statutory amendments followed seminal case law and the result was an expansion of the responsibilities of the Service.

A full explanation of the evolution of the Service’s functions, powers and duties is beyond the scope of this article, but suffice it to say that the most prominent expansion of the Service’s workload resulted from the recodification of the MHL in 1972. Following the 1972 recodification, MHIS was to interview and advise patients of their legal rights, regardless of their age or legal status. MHIS jurisdiction was also, for the first time, extended to alcoholism facilities and facilities for developmentally disabled individuals.²⁶ As a result, the mandated workload of the Service was estimated to increase from 14,000 to 67,000 patients.

Initially, only the MHIS for the Second Department employed staff attorneys. The other Departments were staffed with mental health information “officers” and assistants.²⁷ Following the 1966 Court of Appeals right to counsel decision in *People ex rel. Stanley*, guidelines were adopted which permitted the First Department MHIS to assume the role of the patients’ counsel in civil commitment proceedings. Indeed, the MHIS First Department was required to represent patients whom it recommended for discharge, subject to the right of the patient to hire

counsel of her own choosing.²⁸ By the 1980s all four departments had followed suit. As noted by Mr. Sundram in the 1980 CQC report:

These procedures for the First Department had critical implications for the operation of the Service. First, a more traditional lawyer-client role for MHIS emerged in those cases where it was recommending discharge. Secondly, it emphasized the court service role where MHIS disagreed with the client, and in such cases alternative legal representation was to be provided to the client. In this latter situation, the potential conflict between the roles of the legal representative and court aide were recognized. However, the ethical dilemma for the Service in gathering confidential information as a client representative and later using this information to support the hospital’s position in its capacity as court aide was not resolved.²⁹

The foregoing observations echoed concerns that had been previously expressed in a 1973 Assembly Ways and Means Committee report which stated that “it is difficult to reconcile the MHIS’ responsibility to make a report to the court for its use in rendering an objective determination and at the same time represent the patient in the role of advocate.”³⁰ Thus, in its 1980 report, CQC recommended that the Service’s reporting function be eliminated and the mission of MHIS be otherwise refined in response to the changing legal landscape and significantly increased demand for legal services to establish, protect and vindicate the legal rights of mentally disabled individuals.³¹ In 1986, the MHIS was renamed the Mental Hygiene Legal Service and the agency evolved into a multi-faceted legal advocacy program providing a broad range of protective legal services and assistance to mentally disabled individuals.³²

II. The Present

Giving Voice to the Vulnerable

—Honorable Gail Prudenti³³

The present mission of the Service is to ensure that the liberty interests of its constituents are not restricted to any extent greater than is absolutely necessary for their protection and the protection of others.³⁴ The Service also strives to protect property interests and seeks to advocate in a manner which enhances and improves the quality of life enjoyed by its constituents whenever possible.

The mandated activities of the Service are statutorily prescribed by article 47 of the MHL and further defined by uniform regulations of the Presiding Justices of the Ap-

pellate Divisions.³⁵ Section 47.03 of the MHL enumerates the core functions and responsibilities of the Service as follows: to study and review the admission and retention of all patients or residents, including the person's willingness and the facility director's determination as to the suitability of the person's status; to inform patients, residents and others of the procedures for admission and retention, and to the legal right to a judicial hearing, counsel and independent medical opinion; and to provide legal services and assistance to patients or residents and their families with respect to admission, retention, care and treatment. The Service is also authorized to take any legal action it deems necessary to safeguard patients or residents from abuse and mistreatment, which may include investigating any such allegations. In 2007, its jurisdiction was expanded to represent sex offenders in article ten civil management proceedings.³⁶

Pursuant to its enabling statute, MHLS provides legal services and assistance to its constituents under articles 9, 10, 15, 29, 33, 79, and 80 of the MHL,³⁷ to prisoners under sections 402 and 508 of the Correction Law,³⁸ to incapacitated criminal defendants and those found not responsible who are committed to treatment facilities under article 730 and section 330. 20 of the Criminal Procedure Law, to individuals who are the subject of guardianship proceedings under article 81 of the MHL and article 17-A of the Surrogate's Court Procedure Act (SCPA), and to patients who are confined in facilities under sections 251 and 353.4 of the Family Court Act.

The Service is a small state agency with a large task. In 2011, for example, there were approximately 145,000 MHL article 9 and 15 admissions and legal status conversions at inpatient facilities for mentally disabled individuals. These admissions do not always result in judicial commitment hearings, but in 2011 alone, there were in excess of 21,000 judicial proceedings of various types commenced which involved MHLS constituents and were handled by the Service.

The Service has additional duties and responsibilities with respect to the quality of care and treatment and to protect the civil rights of patients, generally. Among the functions undertaken by the Service consistent with its mandate are:

- to remedy conditions of confinement where abuse and mistreatment has occurred, investigate allegations of abuse and mistreatment and other incidents, and ensure that corrective action is taken to protect patients from harm;³⁹
- to monitor and take action to ensure that treatment is otherwise being rendered in compliance with applicable laws, including, but not limited to ensuring that patients are not improperly restrained or secluded;⁴⁰
- to ensure that patients are afforded adequate and appropriate treatment and safe discharge plans;⁴¹

- to ensure that non-English speaking patients and residents are afforded appropriate services;⁴²
- to enforce the Americans with Disabilities Act (ADA) and implementing regulations, to ensure that deaf individuals receiving services for a mental disability are afforded access to sign language interpreters, that individuals with physical disabilities are afforded proper accommodations and that mentally disabled individuals are otherwise afforded appropriated community integration opportunities;⁴³
- to ensure that facilities are complying with New York's health care proxy and do-not resuscitate statutes;⁴⁴
- to ensure that mentally retarded and developmentally disabled persons receive therapeutic and efficacious medical treatment and proper consent for such treatment where necessary, as well as engaging in a mandatory review of a guardian's decision to withdraw or withhold life-sustaining treatment from a mentally retarded ward;⁴⁵
- to protect the rights of involuntarily retained patients and residents to refuse or receive appropriate treatment;⁴⁶
- to ensure that patients and residents are treated in the least restrictive environment consistent with their clinical needs;⁴⁷
- to ensure that the statutory provisions with respect to a patient's right to maintain his or her own money and personal property are followed;⁴⁸
- to maintain communication and visits with persons outside of the facility and to ensure that patients and residents may access their clinical records;⁴⁹
- to ensure that regulations are followed before patients or residents are permitted to be served with legal process in a mental hygiene facility.⁵⁰

Thus, MHLS, in the exercise of its representational role, has been at the forefront in advocating patient liberty interests,⁵¹ in protecting patient privacy interests⁵² and challenging aspects of the state statutory commitment schemes where procedural due process deficiencies are identified.⁵³ In addition, the Service annually receives and addresses thousands of inquiries and complaints by patients, family, friends, facility staff and others concerning care and treatment.

On a frequent and consistent basis, MHLS attorneys and officers find themselves in correctional facilities, secure treatment facilities, inpatient psychiatric wards, alcoholism and substance abuse facilities, veteran's hospitals, community residences, day treatment programs, nursing homes, intensive care units, and private homes, addressing constituent concerns.

At any one time, MHLS staff could be selecting a jury for commitment hearing conducted pursuant to articles 9, 10 or 15 of the MHL or section 330.20 of the Criminal Procedure Law or reviewing a guardian's decision to withhold or withdraw life-sustaining treatment from a mentally disabled individual. On any given day, MHLS staff may be conducting an investigation as the court evaluator or counsel in a guardianship proceeding, while a colleague argues a case in the Appellate Division or Court of Appeals, while still another staff member offers a presentation at a local hospital to explain the legal rights of patients.

Whether engaged in judicial or "non-judicial" advocacy, much of the work of the Service will never find its way into a judicial decision or published report. In psychiatric hospitals and developmental centers, MHLS attorneys and officers negotiate on behalf of its clients in a manner which may lead to a client's discharge or abbreviated detention without the need for judicial intervention.⁵⁴ MHLS staff similarly advocate to promote and protect the liberty and property interests of individuals in community-based facilities.

While representing individuals with diminished capacity, MHLS attorneys are ethically required to maintain a conventional attorney-client relationship as far as reasonably possible.⁵⁵ Challenges abound, however, as it is difficult on the one hand to advocate for the wishes and preferences of a person who may be acutely psychotic, or to know how to best represent the interests of a client unable to communicate, on the other. In order to perform its functions, MHLS attorneys and officers must be able to display a "healthy measure of humility, awe and humor" as they adapt conventional professional responsibilities to sometimes unconventional clients and circumstances.⁵⁶

III. The Future

We hope the effects of this study will be felt for many years, years which we trust will mark a brighter future in the care of the mentally ill.

—Mental Illness and Due Process⁵⁷

The legacy of the Service as well as its future is the product of its personnel, many of whom are career employees. The attorneys, officers and administrative staff of MHLS, while diverse in backgrounds, are motivated and inspired by a singular purpose to be a voice for the vulnerable now and in the future.⁵⁸ The Service was not without its critics at its inception, who feared the agency would have counter-therapeutic effects,⁵⁹ and today inevitable tensions continue at the interface of law and psychiatry. Nor is the Service immune from criticism related to the manner in which it exercises its mandate or deploys its resources. Nevertheless, going forward, the fundamental objectives of the agency appear inviolate. Indeed, the constitutionality of New York's medical model of admis-

sion and retention continues to depend in large part upon the viability and ability of the Service to carry out its functions, powers and duties,⁶⁰ and the mission of the agency has been expanded to ensure the right to counsel in a variety of civil proceedings.⁶¹

To understand the challenges of the future, past is prologue. As it was in 1986, the mental health system is now undergoing rapid and dramatic changes relative to the management, design and structure of state agencies operating or overseeing programs for vulnerable persons.⁶² While it is foreseeable that the agency's core functions will continue unaltered, MHLS attorneys and officers may be called upon to advocate in non-traditional ways. For example, and with greater regularity, the Service may be advocating to establish or maintain the eligibility of its constituents to receive essential services, as opposed to interposing objections to care and treatment. No doubt the agency will also have a greater role to play in health care advocacy. These are functions and duties that were little emphasized at the Service's beginnings, which are now central to its mission.

Another important challenge going forward for the Service relates to how it delivers advocacy services. The Service pioneered the establishment of offices in or near psychiatric hospitals and developmental centers, bringing advocacy services directly to the patients and residents of facilities. To enable the Service to perform its on-site legal advocacy function, MHLS is to be afforded access "at any and all times" to facilities for mentally disabled individuals.⁶³ While the Service maintains offices in dozens of state and municipal psychiatric hospitals and developmental centers throughout New York State, many of these facilities are being closed in favor of smaller, community-based facilities. As an example, in 1978, there were approximately 16,447 institutional beds in developmental centers throughout New York State which were operated by the Office of Mental Retardation and Developmental Disabilities (OMRDD).⁶⁴ Today there are currently fewer than 2,100 developmental center beds. By contrast, approximately 31,900 beds now exist in the community.⁶⁵ Reaching its constituent populations remains a priority for the Service, and will require innovation by the agency to ensure that the needs of mentally disabled individuals for legal advocacy and oversight are met, regardless of where they are served.

IV. Conclusion

The motivation of the staff of MHLS is inevitably drawn from the life stories and experiences of the people served by the agency who display tremendous grace, courage and resiliency in the course of their daily lives. Dramatic changes in the service delivery system will not lessen, and more likely, will accentuate the need for strong legal advocacy on behalf the Service's constituents now and in the future.

Endnotes

1. 1964 N.Y. Laws ch. 738.
2. 1985 N.Y. Laws ch. 789.
3. Raj K. Gupta, *New York's Mental Health Information Service: An Experiment in Due Process*, 25 RUTGERS L. REV. 405, 410 (1970-1971) [hereinafter *An Experiment in Due Process*].
4. *Id.*
5. N. Y. Mental Hygiene Law § 47.03(a) (MHL).
6. See, e.g., *People ex rel. Rogers v. Stanley*, 17 N.Y.2d 256, 270 N.Y.S.2d 573 (1966); *People ex rel. Woodall v. Bigelow*, 20 N.Y.2d 852, 285 N.Y.S.2d 85 (1967) (right to counsel in involuntary civil commitment proceedings); *In re Buttonow*, 23 N.Y.2d 385, 297 N.Y.S.2d 97 (1968) (services of MHIS extended to voluntary patients); 1970 N.Y. Laws ch. 996 (services of MHIS extended to incapacitated defendants and those found not guilty by reason of mental disease or defect); *Rivers v. Katz*, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986) (patients entitled to a hearing and counsel prior to being subjected to involuntary medication); 1992 N.Y. Laws ch. 698 (services of MHLS extended to persons alleged to be incapacitated in article 81 guardianship proceedings); 1994 N.Y. Laws ch. 560 (services of MHLS extended to individuals subject to assisted outpatient treatment proceedings); 2007 N.Y. Laws ch. 7 (services of MHLS extended to sex offenders subject to civil management proceedings); 2010 N.Y. Laws ch 111 (MHLS given responsibilities with respect to management of patient funds).
7. MHL § 47.01; MHL § 1.03(6).
8. THE SPECIAL COMMITTEE TO STUDY COMMITMENT PROCEDURES OF THE ASSOCIATION OF THE BAR OF THE CITY OF NEW YORK IN COOPERATION WITH CORNELL LAW SCHOOL, MENTAL ILLNESS AND DUE PROCESS: REPORT AND RECOMMENDATIONS ON ADMISSION TO MENTAL HOSPITALS UNDER NEW YORK LAW 13 (1962) [hereinafter MENTAL ILLNESS AND DUE PROCESS].
9. *Id.* at 15. The Special Committee included judges, the Commissioner of Mental Hygiene, a law school dean, the director of a state hospital and several practicing lawyers. One member of the Special Committee, Simon Rosenzweig, Esq., would later be appointed as one of the original MHLS directors for the First Department.
10. MENTAL ILLNESS AND DUE PROCESS at 14–15.
11. *Id.* at 51, 106–107; *An Experiment in Due Process* at 411.
12. *Id.*
13. MENTAL ILLNESS AND DUE PROCESS at 116–17.
14. *Id.* at 7.
15. *An Experiment in Due Process* at 413, n. 36; N.Y. MHL § 87 (1964). The patient's remedy also included a rehearing and review by jury if one was requested within 30 days of certification. See *In re Coates*, 9 N.Y.2d 242, 213 N.Y.S.2d 74 (1961).
16. MENTAL ILLNESS AND DUE PROCESS at 22; see also Note, *The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill*, 67 COLUM. L. REV. 672, 673 n.9 (1967).
17. MENTAL ILLNESS AND DUE PROCESS at 22; 1964 N.Y. Laws ch. 738.
18. N. Y. MHL § 88 (1964).
19. MENTAL ILLNESS AND DUE PROCESS at 19.
20. *Id.* at 21.
21. *An Experiment in Due Process* at 415.
22. Mr. Sundram currently serves a Governor Andrew Cuomo's Special Advisor on Vulnerable Persons.
23. *Baxstrom v. Herold*, 383 U.S. 107 (1966).
24. *People ex rel. Rogers v. Stanley*, 17 N.Y.2d 256, 270 N.Y.S.2d 573 (1966).
25. *People v. Lally*, 19 N. Y.2d 27, 277 N.Y.S.2d 654 (1966).
26. 1972 N.Y. Laws ch. 251; see Memorandum from Murphy to the New York State Assembly Ways and Means Committee entitled *The Mental Health Information Service: A Program Review and Suggestions for Reform* (July 31, 1973) (unpublished) [hereinafter *Program Review and Suggestions for Reform*].
27. State Commission on Quality of Care for the Mentally Disabled, Clarence Sundram, Chairman, *Strengthening Patient Advocacy: A Review of the Mental Health Information Service*, p. 18 (1980) [hereinafter *Strengthening Patient Advocacy*].
28. *Id.*
29. *Id.* at 18.
30. See *Program Review and Suggestions for Reform* at 12.
31. *Strengthening Patient Advocacy*, at iv–v.
32. 1985 N.Y. Laws ch. 789.
33. Gail Prudenti, *Giving Voice to the Vulnerable*, N.Y.L.J., Jan. 24, 2011, p. 9, col. 3.
34. *Id.*
35. N.Y. Comp. Codes R & Regs. tit. 22, §§ 622, 694, 823, 1023 (N.Y.C.R.R.).
36. 2007 N.Y. Laws ch. 7.
37. MHL art. 9 (civil admission and retention to psychiatric hospitals); MHL art. 10 (sex offender civil management); MHL art. 15 (civil admission and retention in developmental centers); MHL art. 29 (general provisions relating to in-patient facilities); MHL art. 33 (rights of patients); MHL art. 79 (admission and retention in veteran's hospitals); MHL art. 80 (surrogate decision making for patients who lack capacity).
38. Commitment of mentally disabled individuals in local and state correctional facilities.
39. See, e.g., *Hirschfeld v. N.Y.C. Health and Hospitals Corp.*, 07-CV-1819 (co-counsel with New York Civil Liberties Union and Kirkland and Ellis LLP); *Mental Hygiene Legal Serv. v. Maul*, 36 A.D.3d 1133, 827 N.Y.S.2d 777 (3d Dep't 2007), *lv. to appeal den.*, 8 N.Y. 812 (2007).
40. See, e.g., *Mental Hygiene Legal Serv. v. Cuomo*, 195 A.D.2d 189, 607 N.Y.S.2d 179 (3d Dep't 1994).
41. See, e.g., *Koskinas v. Boufford*, 80 N.Y.2d 684 (1984); *Mental Hygiene Legal Service v. Maul*, 10 Misc. 3d 348, 803 N.Y.S.2d 399 (S. Ct. Franklin Co. 2005) *aff'd. Dix v. Maul*, 38 A.D.3d 972, 831 N.Y.S.2d 564 (3d Dep't 2007).
42. See, e.g., *W.G. v. Morris*, 95-CV-2106 (co-counsel with Disability Advocates, Inc).
43. See generally 42 U.S.C. §§ 12131 *et seq.*; *Olmstead v. L.C. ex rel Zimring*, 527 U.S. 581 (1999); 14 N.Y.C.R.R. §527.4; 14 N.Y.C.R.R. §633.4.
44. See, e.g., *In re Leonard B.*, 164 Misc. 2d 518, 625 N.Y.S.2d 809 (Sup. Ct. Albany Co. 1995), *mod. and affirmed*, *Finn v. Leonard C.*, 221 A.D.2d 896 (3d Dep't 1995).
45. See generally, MHL art. 80; Surrogate's Court Procedure Act § 1750-b (SCPA).
46. See, e.g., *N.Y.C. Health and Hospitals Corp. V. Stein*, 70 Misc.2d 944, 335 N.Y.S.2d 461 (S. Ct. N.Y. Co. 1972); *Rivers v. Katz*, 67 N.Y.2d 485 (1986); *J.S. v. Morris*, 95 Civ. 0117 (co-counsel with Disability Advocates, Inc.).
47. See, e.g., *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161 (1973); *McGraw v. Wack* 220, A.D. 2d 291, 632 N.Y.S.2d 135 (1st Dep't 1995); *Bernstein v. Pataki*, 233 F.Appx. 21 (2d Cir. 2007).
48. See, e.g., *State v. Muller*, 179 Misc. 2d 980, 686 N.Y.S.2d 652 (Ct. Cl. 1990), *aff'd*, 280 A.D.2d 923, 719 N.Y.S.2d 916 (4th Dep't 2001), *lv. to appeal den.*, 96 N.Y.2d 715 (2001).
49. See, MHL §§ 33.05, 33.07, 33.16.
50. See, *Mental Health Info. Servs. v. Schenectady County Dept. of Social Servs.*, 128 Misc.2d 282, 488 N.Y.S.2d 335 (Sup. Ct. Albany Co. 1985).
51. See *Rivers v. Katz*, 67 N.Y.2d 485 (1986).

52. See *Hirschfeld v. Stone*, 193 F.R.D. 175 (S.D.N.Y. 2000) (co-counsel with Legal Aid Society); *Miguel M. v. Barron*, 17 N.Y.3d 37 (2011).
53. See, e.g., *Ritter v. Surlis*, 144 Misc. 2d 945, 545 N.Y.S.2d 962 (Sup. Ct. Westchester Co. 1988); *In re David B. and Richard S.*, 97 N.Y.2d 267 (2002); *Harkavy v. Consilvio*, 7 N.Y.2d 607 (2006), *MHLS v. Cuomo*, 785 F. Supp. 2d 205 (S.D.N.Y. 2011).
54. *An Experiment in Due Process* at 488.
55. N.Y. Rules of Professional Conduct: Rule 1.14.
56. *Stanley S. Herr, Representation of Client with Disabilities: Issues of Ethics and Control*, Vol. XVII Review of Law and Social Change (1989-90) 609, 650.
57. *Mental Illness and Due Process* at viii-ix.
58. Gail Prudenti, *Giving Voice to the Vulnerable*, N.Y.L.J., Jan. 24, 2011, p. 9, col. 3.
59. *Strengthening Patient Advocacy* at 10.
60. *Project Release v. Prevost*, 551F. Supp. 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983).
61. MHL § 9.60, 81.10(c).
62. Clarence Sundram, *The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse and Neglect*, <http://www.governor.ny.gov/assets/documents/justice4specialneeds.pdf> (last visited Oct. 16, 2012).
63. MHL § 47.03(d).
64. Now known as the Office for People with Developmental Disabilities (OPWDD).
65. *Office for People with Developmental Disabilities, 2012 Interim Report*, <www.opwdd.ny.gov/sites/default/files/documents/interim_RPT_2012_Final.pdf> (last visited June 12, 2012).

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The NYSBA Family Health Care Decisions Act Information Center

The NYSBA Health Law Section has a web-based resource center designed to help New Yorkers understand and implement the Family Health Care Decisions Act—the law that allows family members to make critical health care and end-of-life decisions for patients who are unable to make their wishes known.

The screenshot shows the website interface for the NYSBA Family Health Care Decisions Act Information Center. At the top, there is a navigation bar with links for 'My NYSBA | Login | Join | Renew | Web Survey | FAQ | Online Store | About NYSBA | Contact | Site Map'. Below this is the NYSBA logo and the text 'NEW YORK STATE BAR ASSOCIATION Serving the legal profession and the community since 1876'. A 'MEMBER LOGIN' section includes a 'username' field, a password field, and a 'Login' button. There is also a 'JOIN / RENEW' button. The main content area is titled 'Family Health Care Decisions Act Information Center' and contains the following text: 'New York's Family Health Care Decisions Act (FHCDA)¹ establishes the authority of a patient's family member or close friend to make health care decisions for the patient in cases where the patient lacks decisional capacity and did not leave prior instructions or appoint a health care agent. This "surrogate" decisionmaker would also be empowered to direct the withdrawal or withholding of life-sustaining treatment when standards set forth in the statute are satisfied.' Below this, it states 'The key provisions of the FHCDA became effective on June 1, 2010.' and 'The FHCDA Information Center is a project of the NYSBA Health Law Section. It is designed as a resource for all persons – including health care professionals, health care attorneys, advocacy groups, policymakers and members of the public – who are seeking information about the FHCDA.' A list of resources is provided, including:

- Summary of Key Provisions of the FHCDA (PDF)
- Text of the FHCDA (PDF)
- Legal Journal Articles about the Family Health Care Decisions Act
- Frequently Asked Questions (including Q&A's added or revised on September 9, 2010)
- FHCDA List Serve
- Related Laws and Regulations
- NYS Department of Health Materials
- Dear Hospital CEO Letter (NYS Dept. of Health, June 1, 2010) (PDF)
- Dear Nursing Home Administrator Letter (NYS Dept. of Health, June 1, 2010) (PDF)
- Deciding About Health Care: A Guide for Patients and Families (NYS Dept. of Health, 2010) (PDF)
- AIDS Institute Fact Sheet: The FHCDA and AIDS/HIV (PDF)
- When Others Must Choose: NYS Task Force on Life and the Law (1992)
- Information about Model Hospital and Nursing Home FHCDA Policies and Forms
- Information about MOLST – Medical Orders for Life-Sustaining Treatment
- Surrogate Decision-Making for Incapable Adult Patients with Mental Disabilities: A Chart of the Applicable Laws and Regulations (PDF) (Revised as of March 2, 2011)

www.nysba.org/fhcda

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