



STRENGTHENING PATIENT ADVOCACY:
A Review of the Mental Health Information Service

A Report by

**The State Commission on Quality of Care
for the Mentally Disabled**

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PREFACE

The Commission undertook this study of the Mental Health Information Service (MHIS) as a result of an emerging legislative and executive consensus that the purpose and direction of MHIS needs reevaluation. Perhaps most significantly, the passage of constitutional amendments centralizing administrative power within the judiciary in a chief administrator of the courts necessitates a rethinking of the present structure of MHIS administration and supervision by four directors responsible to the Presiding Justices of each Judicial Department. Moreover, dramatic changes in the nature of the mental hygiene system and in the availability and expectations of advocacy services also point to the need for reassessing the role of MHIS in the mental hygiene system.

The unprecedented explosion in civil rights legislation and litigation that we have experienced since the creation of MHIS in 1964 has broadened and deepened the recognition of the rights of mentally disabled persons. This in turn, has significantly increased the demand for legal services to establish, protect, and vindicate these legal rights. As legal and clinical issues surrounding the treatment of the mentally disabled spilled into public forums, they provided an added impetus to the movement, already underway, to changing the focus of care and treatment of the mentally disabled away from the institution and into the community.

Community placement of large numbers of mentally disabled persons generated, and continues to generate intense debate about the nature of effectiveness of the care provided to persons suffering from mental disability.

The state and federal governments and private organizations and associations have responded in a variety of ways to these developments. Advocacy groups of concerned parents and relatives, with varying degrees of militance, have sprung up all across the country. The American Civil Liberties Union has intensified its legal advocacy for the mentally disabled by participating in the creation of a Mental Health Law Project. The American Bar Association has established a Commission on the Mentally Disabled. The federal government has enacted a bill of rights for developmentally disabled persons and required states receiving federal funds to create Protective and Advocacy Services for the Developmentally Disabled. Congress is currently considering similar measures on behalf of the mentally ill. The Justice Department has been seeking congressional approval of legislation authorizing it to sue states which pervasively violate the civil rights of institutionalized persons.

The Legislature of the State of New York has also responded in a variety of ways. It has changed the composition of the boards of visitors of mental hygiene facilities -- the State's oldest advocacy group -- to require representation

of parents and other relatives of patients, and former patients, on the boards. The requirements for visiting and inspecting mental hygiene facilities have been strengthened. More importantly, the Legislature, at the request of Governor Hugh L. Carey, created this independent Commission as a permanent, full-time monitoring agency over the mental hygiene system.

Prior to the creation of this Commission in 1977, however, the Legislature significantly expanded and changed the specific functions of MHIS, recognizing the reality that MHIS was the only available permanent and full-time independent entity knowledgeable about the workings of the mental hygiene system, particularly in the area of patient advocacy. In so doing, a developing internal conflict in the role of MHIS, which was originally conceived of as essentially a service to the courts, was exacerbated. Realizing the need for legal counsel for patients, not merely in the admission and retention process, but in other aspects of institutional life, in the discharge process and in the resolution of problems created by institutionalization, the Legislature turned to MHIS for solutions. The solutions of yesterday have become the problems of today.

Aside from the inherently conflicting roles of both court service and patient advocate thus created, the imposition of new duties without concomitant increases in staff and resources has created difficulties for MHIS. Repeated

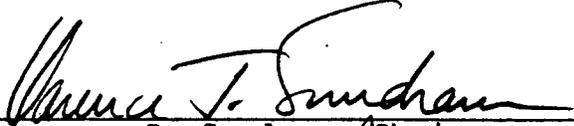
requests for additional funding have been unsuccessful largely because of a legislative inability to obtain coherent and meaningful assessments of the actual workload of MHIS.

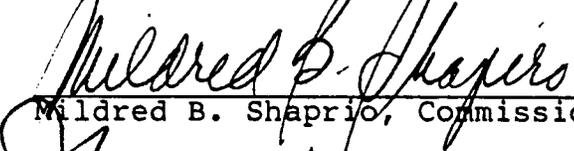
Failing the receipt of additional funds, the administrative fragmentation of MHIS did not readily lend itself to the establishment of uniform priorities consistently applied across the State in an effort to maximize important services within limited resources.

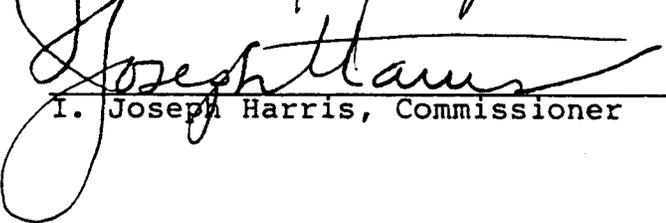
It is easily understandable within this context, that the services actually provided within the four judicial departments would vary widely, that staffing patterns would differ significantly, and that coordination of MHIS activities with similar or related activities of other agencies or organizations would be spotty or non-existent.

This is not to suggest that whatever services are provided by MHIS are not valuable. In many non-State-operated institutions, MHIS staff are the only independent observers who are present with any degree of regularity. As a result of their function of informing patients of their rights, they are also generally accessible to patients and their families and serve as an important, if informal, source of information on many matters not technically within their function. There is clearly a continued and vital role for MHIS to play within the mental hygiene system, but, given the sweeping nature of changes in advocacy for the mentally disabled, refining the service's functions is essential.

Through this report, the Commission hopes it can assist legislative, executive, and judicial decision-makers to focus their concerted energies on strengthening, reshaping, and redirecting MHIS as it prepares to cope with an environment that has changed enormously since its creation.


Clarence J. Sundram, Chairman


Mildred B. Shapiro, Commissioner


I. Joseph Harris, Commissioner

SUMMARY

The Mental Health Information Service was created to protect the legal rights of mentally disabled or allegedly mentally disabled persons. In carrying out this mission, the Service has not only served persons admitted for care and treatment, but also has provided assistance to the courts, similar to that of a probation service. However, this task has grown more complex as the rights of the mentally disabled have been further defined by court decisions and legislative action. The MHIS more and more has become the "guardian of the legal rights" of mentally disabled persons with the addition of new functions, including legal representation of patients, and the expansion of its clientele to include the developmentally disabled and persons suffering from alcoholism. As the Service has been required to assume new responsibilities, analyses of the performance and operation of MHIS have begun to raise serious questions about the role of the agency.

Scholars and the legal community have questioned the propriety of MHIS serving the patients as an advocate, and the courts as an aide. However, it was not until a review of MHIS was undertaken by the Assembly Ways and Means Committee in 1973 that the purpose and structure of the Service became a legislative issue. Numerous attempts have been made by the Legislature to restructure the MHIS, and

all have failed. Subsequent to the legislative review, other events have taken place, including the creation of the Commission on Quality of Care for the Mentally Disabled and the passage of constitutional amendments regarding the organization of the judiciary, which further necessitate a careful and deliberate appraisal of MHIS. This report represents the beginning of such an effort.

FINDINGS

The functions and the persons served by the Mental Health Information Service have been vastly expanded since its creation (see Report, pp. 16-25). However, during this period of time, the core functions of MHIS--legal representation of patients in the process of admission to or retention in mental hygiene facilities--have not been drastically modified, except for the addition of such duties as investigating allegations of abuse and providing legal representation to patients or residents, and reviewing the status of persons conditionally released from or voluntarily admitted to a mental hygiene facility (see Report, pp. 23-24). Previous studies of MHIS have noted that some of the Service's responsibilities represent inherent role conflicts for the agency and that these functions should be modified in order to achieve a consistency in purpose (Report, p. 15). More precisely, the major conflict that has been cited is the Service's responsibility to provide independent legal

representation for patients and, at the same time, to provide the court with confidential assessments of patients or residents (Report, p. 15). This same dilemma exists for the Service in relation to its authority to investigate allegations of abuse or mistreatment, and to review the suitability of patients to remain in a conditional release or voluntary admission status vis-a-vis its responsibility to serve as counsel (Report, pp. 40-43 and 44-45).

The diversity of functions for MHIS was reflected in the varying staffing patterns implemented in each of the four Judicial Departments. Although the Second Department was the only judicial department to have staff lawyers when the Service began operation, currently three of the four departments (the exception being the Fourth Department) are staffed primarily by lawyers (Report, pp. 9 and 46).

The major concern that has been expressed regarding the management of the agency is the lack of uniformity in services available and the failure of the Service to emerge as a Statewide agency (Report, pp. 45-49). However, the issue of the Service's organizational structure is no longer just a management concern with the passage of the constitutional amendments requiring a uniform court system administered by the Office of Court Administration (Report, p. 32).

The second major area of concern affecting the Service's operation has been its organizational placement in State government and the management of the agency's operation.

Although most legislative proposals to reorganize MHIS have maintained the Service in the Judiciary, there are strong and persuasive reasons for viewing placement in the Executive branch as another option.

With the development and probable expansion of federally-required protection and advocacy services, and new State initiatives such as the creation of the Commission on Quality of Care for the Mentally Disabled, there is a need to examine the various options for placement in State government.

RECOMMENDATIONS

The recommendations made in this report involve the functions, management, and organizational placement of the Service. The following is a brief overview of the major recommendations and options:

1. The administration of MHIS should be centralized regardless of its organizational placement whether in the Judiciary or the Executive Department.
2. A governing body should be established to serve as a board of directors of MHIS which would establish Statewide priorities for the agency and evaluate its performance.
3. The functions of MHIS should be streamlined so that the agency primarily is responsible for legal/advocacy services. Staffing patterns should be adjusted uniformly to reflect this legal orientation.
4. The Service should coordinate its efforts with other advocacy agencies so as to avoid needless duplication and to maximize existing resources.

Report on the
Mental Health Information Service

Introduction

This report is a review of the development, evolution, and operation of the Mental Health Information Service (MHIS). The need for such a review was conveyed by the Chairman of the Commission on Quality of Care for the Mentally Disabled, Clarence J. Sundram, at his confirmation hearing before Senator Frank Padavan, Chairman of the Senate Mental Hygiene and Addiction Control Committee.

"Another area of concern to which the Commission will attempt to devote its attention is patient advocacy—a function, at least in part, performed by the Mental Health Information Service. With the passage of the constitutional amendments on court reorganization which removed administrative functions from the Appellate Divisions, the present method of administering MHIS in the judicial system is probably in need of restructuring and the legislative, executive and judicial branches will have to deal with this issue in the near future... I believe that such a restructuring should be preceded by an analysis of the original concept of the MHIS, an examination of how well that concept has been implemented and a determination of whether changes in the concept or implementation are necessary in view of recent developments in patients' rights litigation..."(1)

I. MHIS - Its Creation

The creation of MHIS is inextricably tied to efforts to evaluate the commitment procedures for mentally ill persons in New York State, which were undertaken by the Association of the Bar of the City of New York and Cornell Law School in 1960. 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 which had already begun a study of the problem in an upstate rural area, commenced an almost two-year intensive study of New York law and practices. In this study, the Special Committee formulated principles to guide their work as well as to serve as a foundation for the analysis and formulation of legislation. These principles are enumerated in Mental Illness and Due Process, the culmination of the study.

"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.

Mental Hospitals are not prisons but they do, by force on body or mind, deprive the patients of some freedom.

Rapid, noncompulsory admission to mental hospitals is good for most patients and helps in allowing effective treatment and early release.

When a person must be sent to a mental hospital against his will, he should not be treated like a criminal and be tried and convicted of being sick. Procedures for his admission are only stepping-stones to treatments.

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."(2)

At the time of the Special Committee's study, New York had seven legal procedures, one voluntary and six nonvoluntary methods, for admission to a mental hospital. However, the Special Committee found that most patients were admitted through a nonvoluntary procedure requiring judicial commitment. This procedure, Section 74 of the Mental Hygiene Law, required the certificate of two doctors with a petition and a court order authorizing the admission to a mental hospital. The patient could be hospitalized for up to sixty days without any other process. Retention of the person for an indeterminate period after this initial sixty day stay required the filing of a certificate by the hospital director with the county clerk. Upon this filing, the court order for hospitalization became final and the person could be retained until discharge.

Raj K. Gupta best summarizes the findings of the Special Committee:

"Although the statute contemplated notice to the allegedly mentally ill person and petitioner, and a hearing where requested... neither was common in practice. Except in New York City, written notice was rarely served on the patient, though relatives or others close to the patient were usually notified. Without notice, the patient was unlikely to know his right to demand a hearing; outside New York City, hearings were rarely held.

Even in New York City, where hearings were more common than upstate, hearings took place in less than one-sixth of all cases of commitment by court

order. At hearings, persons alleged to be mentally ill were rarely represented by counsel, and judges seldom denied commitment applications.

In less than 10 percent of cases throughout the State in which hearings were held, hearings were inadequate and determinations based on scanty evidence. The New York City Bar Association's Special Committee noted: 'If we face the facts, the conclusion is inescapable that initial admission under Section 74 fails in most of these areas to live up to its pretention of being a judicial admission and has become in substance, although not in form, a medical admission.'

Once a person was committed by court order, he was at the mercy of the hospital; whether after a hearing or without one, the period of his hospitalization was largely at the discretion of the institution. The court order directing the institution to observe and treat 'for a period not exceeding sixty days' tended to become 'sixty days' in practice, regardless of the patient's needs. Hospitals routinely filed certificates with county clerks, usually without notice to the patient or his relatives, much before the sixty-day period expired. The mental patient was thereby 'guaranteed' an indefinite stay in the hospital."(3)

In accordance with the Special Committee's principles, a new admission procedure was recommended for the admission of mental patients. The type of admission procedure recommended was a medical approach since it was felt that "initial admission of a nonvoluntary patient to a mental hospital should be a medical admission, decided by doctors, not the court..." The recommended procedure for initial hospitalization was as follows:

"Initial admission to a state mental hospital, licensed private institution or psychiatric receiving hospital shall be authorized on an application for admission by the patient's family or other named persons and the certificates of two physicians, and on confirmation of the need for hospitalization by the medical staff of the institution. This initial admission shall be for a period of sixty days. The admission shall be subject

to the right of the patient to a judicial hearing promptly after admission..."(4)

However, in order to ensure that the patient was fully informed of his rights and that the recommended judicial procedures would provide meaningful protection of the patient's constitutional right to due process, a new agency was recommended to be established. The Special Committee identified this new agency as the Mental Health Review Service, and designated it as their first recommendation. The recommendation and explanation of this proposed agency follows:

"A new state-wide agency, called provisionally the Mental Health Review Service, shall be established as an agency independent of the hospitals and of the Department of Mental Hygiene and shall be responsible to the courts handling mental hospital admissions."

"The Mental Health Review Service will have the duty of studying and reviewing the admission and retention of every nonvoluntary patient. It shall have two aims: (1) to explain to the patient and his family the procedures under which a patient enters and is retained in a mental hospital, and to inform them of the patient's right to a hearing before a judge, his right to be represented by a lawyer, and his right to seek an independent medical opinion, if desired; and (2) to provide the court with information on the patient's case to establish the need for his care and treatment in the hospital or his right to discharge. The Service will also recommend to the court, in all cases where the service sees the need, the desirability of the patient's having legal representation or of his being examined by another psychiatrist."

"Staffed by persons trained for this work, the Mental Health Review Service will have a primary duty to guarantee that patients know their rights and that the court has before it the facts necessary for deciding the question of the propriety of a patient's retention."

"The Mental Health Review Service shall be available in State hospitals, in licensed private institutions, and in psychiatric receiving hospitals-in short, in all mental hospitals which any patients enter against their will."

"Although the primary functions of the Service will relate to nonvoluntary patients, it will also have the duty of explaining to voluntary patients their status and rights and will be available to aid voluntary patients who ask for its help."(5)

The salient features of this proposal were to assure "an opportunity for a full presentation of facts upon which the court may base an informed judgment" and to "pave the way for the introduction of regular methods of nonvoluntary admission to mental hospitals without the necessity for a court order prior to hospitalization" so as to allow "early help for the mentally ill and prompt beginning of treatment".(6)

Following the publication of the Special Committee's report, Mental Illness and Due Process, efforts to draft legislation based on its recommendations began. In both the 1962 and 1963 Legislative Sessions bills were introduced in the New York Senate and Assembly, but were not approved in either house. However, in 1964, another bill to implement the study's findings was introduced, and was passed by both the Senate and Assembly. In this bill, a new Section 88 was added to the Mental Hygiene Law to establish the review agency, called the Mental Health Information Service.(7)

Although the legislation was signed into law in 1964, the implementation of the bill would not occur until September, 1965. This delay in time was to enable both the Department of Mental Hygiene and the four judicial departments to prepare for the new procedures and start up the new Mental Health Information Service. The Governor, in his approval message, also noted this issue:

"There still remain administrative and budgetary details which must be resolved. Since the bill will not become effective until September, 1965, I expect that in the upcoming months those who will be responsible for the administration of this new system will confer with the Director of the Budget with a view towards resolution of these problems."(8)

II. MHIS-Implementation and Initial Operations

With the passage of Chapter 738 of the Laws of 1964, an experiment to protect and ensure the rights of patients in psychiatric facilities had been undertaken. This chapter will examine the steps taken to develop the Service, and the initial operations and performance of this new agency.

During the 1965-66 Legislative Session, the Legislature approved an appropriation of \$440,000 in the Supplemental Budget for the Mental Health Information Service for the remaining seven months of the 1965-66 fiscal year. The actual appropriation for the Mental Health Information Service was broken down among the four departments as follows:

	<u>First</u>	<u>Second</u>	<u>Third</u>	<u>Fourth</u>	<u>Total</u>
Personal	\$ 86,000	\$140,000	\$45,734	\$63,330	\$335,064
Maintenance and Operations	19,307	51,129	13,000	21,500	104,936
Total	\$105,307	\$191,129	\$58,734	\$84,830	\$440,000

This table shows that the Second Department received nearly half of the appropriation, while the First Department received more than the Fourth Department. By projecting this appropriation for a full-year's funding, the Service's annual appropriation would amount to approximately \$754,000.

Although the appropriations varied from Department to department, the most significant variation was the staffing patterns. Of the four departments, only the Second Department had staff attorneys. The remaining departments employed mental health information officers and assistants. The following graph best shows the staffing variation: (9)

	<u>Director</u>	<u>Deputy Director and Supervisors</u>	<u>Information Officers and Assistants</u>	<u>Staff Attorneys°</u>
First	1	1	14	0
Second	1	4	11	6
Third	1	1	4	0
Fourth	1	1	7	0
Total	4	7	36	6

The implementation of Chapter 738 of the Laws of 1964 shows the flexibility provided to the four judicial departments in developing the MHIS. The historical autonomy of the presiding justices within the Judiciary permitted the Service in each Department to assess independently the advocacy needs of the mentally disabled and to develop different approaches to the provision of these services as authorized by statute. Both the Judiciary and the Department of Mental Hygiene were authorized to develop staffing standards jointly for positions in the MHIS. This authority allowed DMH to play a pivotal role in the establishment of this agency. However, as can be seen by the different staffing patterns,

no concerted effort was taken by the Commissioner to develop uniform qualifications for employees of the agency. The vagueness of the purpose of the Service, due to its varied statutory responsibilities along with the administrative autonomy provided to the Presiding Justices and their respective MHIS Directors, resulted in divergent approaches being taken in establishing the Mental Health Information Service.

Initial Operations

The initial operations of the Service were not without controversy. The MHIS came under attack from both the psychiatric profession as well as the legal field. The Editor of the Psychiatric Quarterly, who had previously criticized the legislation establishing the Mental Health Information Service, continued to voice his concern about this new agency and its effect upon patient care.

"The primary effect of the new law has been to orient the patient away from his doctor. Now he looks to the court and to the information officer for release rather than to his doctor...No one has been able to point to a single patient or family who has benefited by the changed procedure. On the contrary, hospital staffs have been diverted from their treatment of patients..."(10)

The Service came under equally harsh attack from the Board of Directors of the New York City Civil Liberties Union. The very existence of the Service and the new medically-oriented involuntary admission procedures were viewed as anathema to the rights of persons being deprived

of their liberty by psychiatric hospitalization. A resolution of the Board of Directors stated:

"Mental illness can never by itself be a justifiable reason for depriving a person of liberty or property against his objection. Even when such deprivations are accompanied by fair procedures, they are unjustified except on a basis - for example, a violation of the criminal law - that would be equally applicable in the absence of mental illness." (11)

Amidst this controversy, the Service's initial operations were of great interest to those who wanted to test this novel experiment in protecting the rights of the mentally ill or allegedly mentally ill. The early analysis of the Service focused on two interrelated issues, staffing and performance.

Staffing emerged as a fundamental issue due to the variations in staffing patterns. As noted previously, the Second Department was the only judicial district which was staffed primarily by lawyers. However, by December 1969, both the First and Second Department were staffed by lawyers, while the Third and Fourth Departments were dominated by social workers (see Appendix A for current staffing patterns). (12)

The reliance upon either social workers or lawyers to perform the functions of MHIS conflicted with the early impressions that a combination of clinical and legal professions were needed if the Service was to function effectively. This perception was based on a model operation best described in the 1970 Report of the Judicial Conference by the First Department:

"Economy of effort, efficiency of service, and more appropriate specialization would be effected if... a small social service unit could be added to assist the lawyers. Such a unit could make its contribution in finding and developing alternatives to hospitalization, especially community resources and facilities covering a wide range of types of accommodations suitable for persons with psychiatric problems. It could also assist in the solution of social work problems and evaluations."(13)

It was envisioned that the coordination of these professionals would bring about "an interchange in attitudes and ideas" and that the legal emphasis upon statutory and constitutional rights (would) be combined with awareness of psychological and social needs.

Although the variations in staffing patterns had important implications for the functioning and effectiveness of the Service, the workload and staff levels of MHIS emerged as a critical issue. This issue was best described by

Gupta:

"While the workload has been increasing, the professional staff of MHIS has not grown much during the last five years. Beside the planned extension of MHIS functions into a new area, the number of applications for retention orders by hospitals has more than doubled between 1967 and 1969, and the number of two-physician-certificate admissions also seems to be on the rise. This increased activity has failed to register a comparable rise in judicial work... This suggests that MHIS is understaffed... If the revised law is to be saved from gradually degenerating into a mere lip service to patient's rights, a review of the staff strength...should receive early attention. Moreover, the lack of sufficient staff to implement the law properly may itself jeopardize the constitutionality of this novel scheme."(14)

In his analysis of MHIS, Gupta compared the workload in each judicial district with the actual performance in order to assess how well the Service was fulfilling its responsibilities. As noted in his study, the patient population in the Second Department represented 69 percent of the total residential population, with the Fourth Department having about 20 percent, the First Department 6 percent, and the Third Department 5 percent.

In terms of performance, Gupta found that most of the work in the First Department was related to initial hospitalization and transfers from receiving hospitals to State hospitals, while the Second Department concentrated its efforts on petitions seeking continued retention of the patient. However, these differences between the First and Second Department were partially the result of New York City residents being transferred after initial hospitalization to the State psychiatric facilities located in the Second Department. The Fourth Department was fairly involved in both initial hospitalization and retention procedures while the Third Department had few requests for retention hearings and an insignificant number of requests regarding initial hospitalization.

Prior to Chapter 738 of the Laws of 1964, once a patient had been hospitalized involuntarily and continued retention approved, a rehearing was seldom held. Greater use of the rehearing procedures was evident. The Second and Fourth

Departments were responsible for nearly all the rehearing procedures from 1967 through 1969 (94 out of 98 rehearing requests). Even though procedures were enumerated in Section 72 of the Mental Hygiene Law for judicial hearings, most of the reviews were initiated by writs of habeas corpus. The reason for this was that Section 72 of the Mental Hygiene Law authorized continued retention for specific periods of time which grew in length after each request was denied, based on the patient's need for continued care (6 months, 1 year, 2 years). However, if a request was initiated by a writ, no such "penalty" for continued confinement existed. In comparison with the 98 rehearings held between 1967 and 1969, 2154 reviews were held as the result of a writ. Of this total, nearly all writs were issued in the First and Second Departments, 938 and 1156 respectively, and undoubtedly were related to the use of lawyers in these two departments.

The relationship of MHIS to the courts was the final area subject to analysis. Included within this category were the Service's court reporting functions and the provision of legal services. The Service was responsible for the preparation of reports to the courts concerning the need for continued hospitalization. These reports contained "all relevant facts surrounding the initial admission or continued retention, the social background and medical history of the patient, and available alternatives to hospitalization", as well as "summations of interviews with patients, hospital staff, family, and friends..."(15)

The implementation and initial operations of the Mental Health Information Service in the Four Departments varied in terms of staffing and functions. These differences were attributed to the perceptions of the presiding justices and MHIS directors, but more importantly to the vagueness of the enabling legislation concerning the role and operations of the Service.

In a study of civil commitment procedures, Judge Joseph Schneider of the Circuit Court of Cooke County, Illinois, examined the operations of the MHIS. In his appraisal, Judge Schneider noted:

"The Mental Health Information Service regards its role as the representative of the patient and as an aide to the court. This is a difficult and somewhat contradictory role in appearance when viewed in the traditional framework of the court process."(16)

In another study of the Service by the New York State Assembly Ways and Means Committee, similar concern was raised about the operations of MHIS.

"The ability of MHIS to represent patients before a court of law poses an interesting question involving conflict of interest... 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 a patient in the role of advocate. Also, the question of patient-lawyer confidentiality intrudes, and it is difficult to reconcile the use of information provided by a patient to MHIS counsel by the court in its deliberations without the patient's consent."(17)

III. Evolution of MHIS

The Mental Health Information Service has undergone a variety of changes, some technical, and others substantive, from its inception. These changes in the Service's responsibilities and clientele have been the result of judicial decisions and legislation. This chapter describes these changes, and includes a budgetary review of MHIS.

The substantive changes made related to the Service generally involved either adding new responsibilities or expanding the scope of its functions. However, the Service was also to undergo a fundamental change, becoming a legal representative for patients in court proceedings. This change, initiated administratively by regulations and subsequently embraced by the Legislature, dramatically altered the primary functions of the Service as a court service, similar to that of the probation service, and an information aide to patients, to that of a legal representative of the patient. The conflict posed by these diverse functions and the dilemma of serving "different masters" has raised serious questions about the proper role or roles for MHIS, to this date. The following is a historical review of these modifications in the Service's operation made by court decisions or legislation.

First, on February 25, 1966, the Supreme Court of the United States held in Baxstrom v. Herold, 383 U.S. 107

(1966) that "patients in Dannemora State Hospital whose sentences are about to expire or have expired must be accorded the same rights as any other civil patients." (18) This decision effectively required that a person be accorded a hearing prior to civil commitment to a correctional hospital as well as the right to periodic review and the services of the Mental Health Information Service.

Second, in May, 1966, the New York State Court of Appeals in People ex rel. Rogers v. Stanley, 17 N.Y. 2d 256, 259 (1966) declared that "an indigent mental patient, who is committed to an institution, is entitled in a habeas corpus proceeding, (brought to establish his sanity), to the assignment of counsel as a matter of constitutional right. In response to this court decision, guidelines were prepared for the MHIS in the First Department to assume this function.

- "1. Whenever the patient is entitled to legal representation, he is to be informed by the Mental Health Information Service that it will provide such legal representation or that he has the option of obtaining counsel of his own choosing (if the patient has funds with which to pay such counsel) (Emphasis supplied).
2. The Service shall, subject to the patient's right to counsel of his own choosing, as stated in subdivision (1), represent any patient as to whom it has recommended discharge from the hospital, convalescent care, weekend privileges, open ward or alternative courses of care and treatment or other relief. Such representation shall continue until the patient's release or any of the foregoing alternative courses has been concluded.

3. In habeas corpus proceedings in which the Service states that it agrees with the hospital's position (that the patient should be retained), as well as all other cases in which the Service reports that it will not represent the patient and the court deems it necessary that the patient have legal representation, then the court shall appoint the Legal Aid Society to represent the patient."(19)

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 legal representative and court aide was 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.

Third, the Court of Appeals in People v. Lally, 19 N.Y. 2d 27 (1966) determined that "persons acquitted of criminal charges, on the defense of insanity, were entitled to the same procedural safeguards, in particular a jury review, as any civil patient."(20) Although the court did not require that the MHIS be included in the process as a procedural safeguard, nonetheless the "implication appeared to be clear that the Service would also be involved."(21)

Fourth, the issue of "Old Law Patients" was the focus of an early judicial decision. In his ruling in In re Kaminstein v. Brooklyn State Hospital, 49 Misc. 2d 57 (1966) Judge Benjamin Brenner criticized the new admission procedures because of the limitations placed upon the Mental Health Information Service. Justice Brenner ordered that the protections offered by the Service be extended to include "Old Law Patients" rather than just those persons admitted on or after the effective date of Chapter 738 of the Laws of 1964 (September 1, 1965). The legislation neither required MHIS to assist those persons admitted before this date nor provided other judicial safeguards to protect persons from unduly being deprived of their liberty. Prompted by this decision, the Commissioner of the Department of Mental Hygiene issued a memorandum (Memorandum #1, March 18, 1966) which required that all patients admitted prior to September 1, 1965, be converted to new admissions status so as to ensure that MHIS would be responsible for these patients. In order to assist MHIS in assuming responsibility for the "Old Law Patients", a two-year schedule was developed for this transition.

In 1968, the Service's functions were extended to a specific group of voluntary patients. The New York State Court of Appeals in Matter of Buttonow, 23 N.Y., 2d 385 (1968), mandated that MHIS provide the same assistance to voluntary patients as involuntary patients. However, this ruling applied only to voluntary patients converted from an involuntary status.

In 1972, the Supreme Court of the United States in Jackson v. Indiana 406, U.S. 715, 738 (1978) held "that a person charged by a state with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant. Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal." This decision had the practical effect of expanding the Service's responsibilities to include incapacitated criminal defendants.

In addition to these court decisions, several legislative actions also altered the role of MHIS. In 1966, Section 102 of the Mental Hygiene Law was amended to require that MHIS be notified when an application for the appointment of a committee for persons in state hospitals (Chapter 550 of the Laws of 1966). This amendment made it necessary that copies of the notice of committee accounts be given to the Service, and that it prepare reports for the court advising it of the status of the patient and other information involving the application.

In 1968, the Department of Mental Hygiene advocated that legislation be passed which would require the Service to be responsible for "Old Law Patients" in order to "obviate the paper work of individually converting each patient to new law admission status." (22) This proposal was enacted as Chapter 1050 of the Laws of 1968.

Chapter 539 of the Laws of 1969 required the Mental Health Information Service to "study and review the admission and retention of all patients under the age of twenty-one." (23) This law was an expression of legislative concern for the so-called "Lost Children", children inappropriately placed in mental hygiene hospitals. The Department of Mental Hygiene had estimated that approximately 30 percent of its children and adolescents in State mental hospitals were "Lost Children."

Also in 1969, the United States Court of Appeals for the Second Circuit [includes Vermont, New York, and Connecticut] in United States ex rel. Schuster v. Herold, 410 F. 2d 1071, (2d Cir. 1969) cert. denied 396 U.S. 847 (1969) declared that "before a prisoner may be transferred to a state institution for insane criminals he must be afforded substantially the same procedural safeguards as are provided in civil commitment proceedings" (24) including the services of the Mental Health Information Service. The following year,

Governor Rockefeller submitted legislation to codify the Schuster decision. Signed into law as Chapter 476 of the Laws of 1970, the statute was designed to "strengthen procedures designed to protect the rights of those persons who would be transferred from correctional facilities to institutions operated by the Department of Correction for the mentally ill and mentally defective."(25) The bill guaranteed to these persons the right to a proper examination, a hearing upon notice, periodic review of the need for commitment, and a jury trial. Copies of the notice, petition and certificates by examining physicians required in order to place an inmate in a correctional facility for the mentally ill or "mentally defective" were to be sent to MHIS.

Also in 1970, the Code of Criminal Procedure was replaced with a new Criminal Procedure Law (Chapter 996). In the revisions of the old code, the Mental Health Information Service was required to provide assistance to patients admitted to a DMH facility because of an acquittal due to insanity as any other patient in the facility. The new law also enlarged the Service's responsibilities by authorizing it to require a court hearing to determine the incapacity or continued incapacity of criminal defendants to stand trial.

In 1972, the Mental Hygiene Law was recodified. The new law, Chapter 251, made several changes regarding the Mental Health Information Service. These changes included: (26)

- mandating the MHIS to see and inform all patients of their legal rights, regardless of status, routinely on its own initiative;
- expanding the scope of the Service to include the mentally retarded and persons suffering from alcoholism; and
- extending its duties to conservatorship proceedings.

Chapter 977 of the Laws of 1972 stipulated that children and adolescents who were transferred from Division for Youth facilities to Department of Mental Hygiene facilities were entitled to the services of MHIS. The law, a result of a study undertaken at the direction of the Presiding Justices of the First and Second Departments, stipulated that these transfers would be made only after notice was given to the child, his parent or guardian, and that an opportunity to be heard and representation by counsel was provided. The MHIS was to be notified by the Director of the Division for Youth upon admission of the child to the hospital.

Chapter 804 of the Laws of 1972 established procedures for the discharge and release of patients to the community. These procedures required MHIS to review the willingness and suitability of released clients to remain in the community. If the Service doubted the suitability or willingness, it was to apply for a court order to determine the client's appropriate placement.

In 1976, Chapter 334 stipulated that the MHIS was to:

"investigate cases of alleged patient abuse and mistreatment, initiate and take any legal action deemed necessary to safeguard the right of any patient to protection from such abuse and mistreatment, and may act as the legal representative of any patient who has not obtained other legal representation...in all proceedings related to incidents of patient abuse and mistreatment."(27)

This law was amended to restrict the scope of the Service's legal representation to those proceedings in which the patient had legal standing. Since the patient was not a party to grievance and disciplinary procedures, MHIS could not provide legal assistance to patients during this labor-management phase of the investigation. Chapter 334 also required the Mental Health Information Service to examine the "results of current grievance and disciplinary procedures in safeguarding the rights of patients involved in incidents of abuse and mistreatment."(28) The Service was required to submit a report on its findings to the Legislature by January 1, 1977.

In 1977, as a result of recommendations made by MHIS in their report to the Legislature on patient abuse and mistreatment, the Service was granted statutory access to all DMH facilities and to all records pertinent to their responsibilities (Chapter 981). The Service also was mandated to perform a second study of the grievance and disciplinary proceedings and to report its findings to the Legislature by January 1, 1978 (Chapter 890).

Other legislation has been signed into law which is more technical in nature:

- Chapter 340 of the Laws of 1969 (Supplemental Budget) altered the titles of the professional staff in MHIS into two groups, legal and non-legal positions;
- Chapter 582 of the Laws of 1971 required banks to furnish financial information concerning patients in State hospitals to MHIS upon its request;
- Chapter 821 of the Laws of 1975 required DMH facility directors to notify MHIS of juveniles, transferred from DFY to DMH facilities, who had escaped or left without consent;
- Chapter 780 of the Laws of 1977 required that MHIS be notified whenever a person, committed to a DMH facility upon a verdict of acquittal by reason of mental disease or defect, petitions for his release or when the Commissioner of DMH makes an application to the courts for release.

Several other bills have been introduced in the Legislature and not signed into law which would have affected the Service's operations.(29) However, of these bills, only two bills have been passed in both the Senate and Assembly and have been vetoed by the Governor. The following is a description of these two bills.

In 1965, the first year of the Service's operation, legislation was introduced in the Senate and Assembly which would have required that the Directors of MHIS appointed by the Presiding Justices be confirmed by the Senate. This legislation (A. 6165/S.4722), vetoed by Governor Rockefeller, was opposed by the Judicial Conference. The State Administrator in his statement in opposition said:

"As a matter of policy, it is unprecedented and undesirable for the legislature to choose or help to choose particular persons who shall be appointed to positions within the judicial branch of government. Indeed, there might even be a broad constitutional question as to whether or not this amendment infringes upon the independent operation of the judicial branch of government..."(30)

The only other bill vetoed involved the legal role of MHIS. Legislation introduced in the Senate (S.6896) would have empowered the MHIS to:

"advise patients of the right to be represented by counsel and to have counsel present at any hearing or proceeding held with respect to a grievance petition or complaint against an employee, agent, or servant of the department, facility, hospital, or school in which the patients reside, with regard to objection to supervision, care, treatment, or rehabilitation, and in the event such patients are financially unable to obtain counsel, make provisions for necessary services on a fee for service basis."(31)

In opposing this legislation, the Office of Employee Relations noted that the disciplinary and grievance procedures were established by contract between the recognized employee representative and the State, and that such modifications of the procedures should be made more appropriately through negotiation than legislation.(32)

The following chart shows the expansion of responsibilities of the Mental Health Information Service.

The Expansion of the Mental Health Information Service

Function	Year	Source
MHIS to assist inmates in correctional mental hospitals	1966	<u>Baxstrom v. Herold</u> , 383 U.S. 107
Right to counsel for indigent mental patients established	1966	<u>People ex rel Rogers v. Stanley</u> , 17 N.Y. 2d 256

Function	Year	Source
MHIS to assume role as legal counsel	1966	Regulations of the First Department
Extension of procedural rights for a civil patient to persons acquitted of criminal charges due to insanity	1966	<u>People v. Lally</u> 19 N.Y. 2d 27
MHIS to serve "Old Law Patients"	1966	<u>In re Kaminstein v. Brooklyn State Hospital</u> , 49 Misc. 2d 57
Old law patients converted to new status to ensure MHIS responsibility	1966	Regulation of the Department of Mental Hygiene (Memorandum #1, March 18, 1966)
MHIS notified of committee proceedings for psychiatric patients and report to the courts on the proceedings	1966	Chapter 550
MHIS required to serve voluntary patients converted from an involuntary status	1968	<u>Matter of Buttonow</u> , 23 N.Y. 2d 385
MHIS required to serve "Old Law Patients"	1968	Chapter 1050
Altered Professional Titles of the Service by establishing legal and non-legal positions	1969	Chapter 340
MHIS to serve all hospitalized children ("Lost Children") regardless of status	1969	Chapter 539
MHIS to provide assistance to prisoners prior to transfer to a state institution for criminally insane	1969	<u>U.S. ex rel Schuster v. Herold</u> 410 F. 2d 1071, (2d Cir 1969) cert. denied 396 U.S. 847, (1969)
MHIS required to assist prisoners transferred from correctional facilities to correctional institutions for the "mentally ill and mentally defective"	1970	Chapter 476
MHIS required to participate in proceedings to determine the "capacity" of criminal defendants to stand trial	1970	Chapter 996 (Criminal Procedure Law enacted)
Banks required to furnish financial records to MHIS upon request	1971	Chapter 582

Function	Year	Source
MHIS required to serve all patients regardless of status; Service responsible to assist the mentally disabled and alcoholics, and the MHIS assigned responsibility for participating in conservatorship proceedings	1972	Chapter 251 (Recodification of the Mental Hygiene Law)
Service required to assist children and adolescents transferred from programs operated by the Division for Youth to DMH facilities	1972	Chapter 977
MHIS functions extended to include incapacitated criminal defendants	1973	<u>Jackson v. Indiana</u> 406, U.S. 715
MHIS required to review the willingness and suitability of released patients, and to apply for a court order to determine the appropriateness if such placement status is questionable	1975	Chapter 804
MHIS notified by DMH of juveniles, transferred from DFY to DMH programs who had left without consent, to be discharged by the facility director	1975	Chapter 821
MHIS responsible for patient abuse investigations and authorized to represent patients in legal proceedings; Service also required to submit a report to the legislature on the adequacy of grievance and disciplinary procedures in safeguarding the rights of patients	1976	Chapter 334
MHIS granted access to DMH facilities and their records	1977	Chapter 981
Service required to submit a second report to the legislature on the grievance and disciplinary procedures	1977	Chapter 890
MHIS to be notified that an application for release has been filed for a patient committed to a DMH facility upon a verdict of acquittal by reason of "mental disease or defect "	1977	Chapter 780

Just as the functions of the Mental Health Information Service have changed over time, the cost for the Service's operation have also increased. The Service's budget, with an original annualized appropriation of \$754,000 in 1965-66, has nearly quadrupled in the span of thirteen years (1965-66 to 1977-78) to \$3,060,071 (See Appendix B for each year's appropriation).

Even though relatively small budgetary increases were approved nearly every fiscal year for MHIS, the vast majority of the budgetary growth took place in two fiscal years, 1973-74 and 1974-75. In these two years, the cost of MHIS rose from \$1,324,961 to \$2,954,460; thus accounting for approximately 70 percent of the total budgetary increase of the Service. Although this growth related to the significant expansion of MHIS responsibility as required by Chapter 251 of the Laws of 1972, subsequent requests for increases, although largely approved, were modified somewhat by the fiscal committees of the Legislature. As noted by the fiscal committees, different "proposals which would modify the direction and focus of the Service's operations" were being reviewed, and "[pending] completion of this, all departmental positions [were] maintained at existing levels." (33) The result for fiscal year 1973-74 was a reduction of \$165,241 from the Judiciary request for MHIS. Again in the following year, the fiscal committees disapproved 25 additional positions of the 40 new items requested by the Judiciary

for the Service. The committees, in explaining their action, noted a "concern with the existing management and expanding program dimensions of the Mental Health Information Service." (34)

This concern for the Service's operation, which seems attributable to the analysis performed by the Assembly Ways and Means staff of MHIS in 1973, has continued to influence the decisions of the fiscal committees regarding increased funding for the Service requested by the Judiciary. The Judiciary's request for 27 additional positions statewide in fiscal year 1977-78 was denied by the Legislature pending receipt of a workload/staffing study. This study, performed by the Office of Court Administration (OCA), was intended to quantify the staffing needs of MHIS.

As a result of the workload/staffing study, OCA estimated that approximately 73 additional professional positions were needed in order for the Service to fulfill its statutory mandate. Based on this new information, OCA concluded that the:

"request for 27 new positions was quite moderate..." and that "[with] implementation of the 27 new positions for 1977-78, the MHIS will gain further experience with its recently expanded duties, permitting more precise examination of staffing requirements and deployment in future years." (35)

However, the study by OCA was not completed in time for the Legislature to reconsider the funding of the positions for the 1977-78 fiscal year.

The following year, the Judiciary made another request for new staff on the basis of the workload/ staffing study. The request, however, for 29 new positions was again denied by the fiscal committees. In apparent dissatisfaction with the first study on MHIS workload, the fiscal committees asked for a new analysis to be made by OCA.

"The request for twenty-nine positions for the Mental Health Information Service is denied without prejudice pending the submission of an output oriented workload study projecting increases in in-court and out-of-court settlements to be processed by these new positions."(36) (Emphasis added)

As can be seen by this overview, recent legislative concern with the functions and organization of MHIS has had two significant outcomes. First, the Judiciary has not been able to gain approval from the fiscal committees for additional funding for new positions despite the additional responsibilities mandated by statute. Given the overriding legislative concern with the functions and organization of MHIS, it appears that until these issues are resolved, the Judiciary probably will continue to experience difficulty in obtaining approval for new positions for the Service. Second, given the overriding legislative concern for the functions and operation of MHIS, no legislation has yet passed both the Senate and Assembly which would resolve the organizational issues of the Service.

IV. Recommendations

The Mental Health Information Service has existed for several years as the only independent, full-time, and professionally staffed State-sponsored advocacy organization for the mentally disabled. As such, it has been required to assume additional functions in response to the diverse problems encountered by these persons. However, recent developments in State and federal policy require an examination of the proper contemporary role of the Service. Some of these developments include:

the reorganization of the courts as a result of constitutional amendments;

the creation of the Commission on Quality of Care for the Mentally Disabled;

the development of a protection and advocacy service for the developmentally disabled; and

the continued legislative interest in assessing the role and structure of MHIS.

This final chapter will analyze the functions statutorily assigned to MHIS, will assess the propriety of the performance of each function by MHIS and the type of staffing required for the performance of such functions, and will make recommendations designed to facilitate efficient allocation of functions and resources to MHIS. In addition, this chapter will address both management and organizational placement issues that require attention if there is to be uniformity in the availability of service from MHIS Statewide.

Functions

Although the statutory responsibilities of the Service have been increased through the years, operationally, its primary responsibilities and types of functions have not been altered drastically. The basic functions of the Service as described in the Mental Hygiene Law include:

- reviewing the admission and retention of persons to mental hygiene facilities;
- informing patients of their rights related to their admission and retention;
- providing information to the courts related to patients or residents in mental hygiene facilities;
- assisting the families of persons admitted for care and treatment in a mental hygiene facility;
- investigating cases of alleged patient abuse;
- examining the grievance and disciplinary procedures; and
- reviewing the status of patients conditionally released from an inpatient facility operated by the State.

1. Representation in Admission and Retention Proceedings

A central purpose of the Service is to provide legal safeguards in the admission and retention procedures so that persons are not deprived of their liberty without due process. As originally envisioned, the Service was to be the critical element in ensuring that judicial review of the need for admission and continued retention was effective and not a procedural rubber-stamp for the clinical determinations of the hospital personnel. The statutory provisions for

court review of admissions and periodic court review to determine the continuing need for care and treatment are essential in protecting the rights of a patient admitted for care and treatment. The need for the Service to be involved in these procedures is critical since without such legal assistance, these procedures would not provide any substantive protection and their constitutionality would be suspect. Analysis of MHIS activities also indicates that this function consumes more staff time than any other function.(37) This function was a cornerstone to the agency's creation and remains as crucial today as ever.

RECOMMENDATION

MHIS SHOULD REMAIN RESPONSIBLE FOR REVIEWING THE ADMISSION AND RETENTION OF PERSONS TO MENTAL HYGIENE FACILITIES AND FOR LEGAL REPRESENTATION OF THE INTERESTS OF PERSONS SUBJECT TO AN ADMISSION OR RETENTION PROCEEDING.

2. Court Reports

The second central function of MHIS is the assistance it provides to courts. The Service has been responsible for preparing reports to judges on pending cases involving mentally disabled or allegedly mentally disabled persons. These reports generally relate the clinical needs and problems as identified by the service provider as well as an impartial assessment by MHIS staff. MHIS staff do not have the clinical capability to "second guess" the judgments of

the psychiatrists, psychologists, or other clinical professionals whose opinions they are assessing. The ability of the Service to effectively represent a patient's or resident's interests is seriously compromised by the Service's preparation of a confidential report to a judge, which is based upon the very information obtained by MHIS under the guise of counsel to the client. Indeed, forwarding such information to a judge without the client's consent seriously weakens the Service's ability to provide legal assistance to the patient or resident in an ethical manner.

As noted by the American Bar Association in the Code of Professional Responsibility:

"Generally, in adversary proceedings, a lawyer should not communicate with a judge relative to a matter pending before, or which is to be brought before, a tribunal over which he presides in circumstances which might have the effect or give the appearance of giving undue advantage to one party..." (Ethical Consideration No. 7-35), and

"[i]n an adversary proceeding, a lawyer shall not communicate, or cause another to communicate, as to the merits of the cause with a judge or an official before whom the proceeding is pending..." (Disciplinary Rule No. 7-110)

Protection of the adversarial process is of paramount importance, and requires that each party have separate counsel for effective representation of the positions of each before the court. By providing independent counsel to a patient or resident, MHIS would preserve the rights of its

client as well as provide the courts with necessary information upon which an informed decision may be rendered regarding that client's status. This conflicting role of court service and legal representative of the patient was initially created administratively, not legislatively, by guidelines promulgated in the First Judicial Department in 1966 (see Chapter II). However, the Legislature has subsequently codified the legal advocate role for MHIS and embellished it with specific advocacy responsibilities (see Chapter III).

It appears to us that MHIS can best serve both the court and the client (and eliminate any potential ethical dilemma) by serving as the legal advocate for the client and presenting to the court the case in behalf of the client. The traditional adversarial process has a proven history of providing the judicial forum with the facts upon which legal judgments ought to be based. If expert witnesses are needed, there is ample precedent for either party to the proceeding or the court itself to see that such witnesses are available.

Clearly, in order for MHIS to fulfill the role recommended, it needs a legal staff.

RECOMMENDATION

MHIS SHOULD NOT BE AUTHORIZED TO PERFORM THIS FUNCTION DUE TO THE INHERENT CONFLICTS BETWEEN SERVICE TO THE COURT AND LEGAL REPRESENTATION FOR THE CLIENT. IF THIS FUNCTION IS RETAINED BY MHIS, THE LEGAL ASSISTANCE FUNCTIONS OF MHIS

SHOULD BE DISCONTINUED AND REPLACED WITH A FEE-FOR-SERVICE ARRANGEMENT.

This latter alternative for the mental health field has, however, been characterized as "a desert in which untrained and unknowledgeable counsel appear." (38)

3. Information

In order for a patient or resident to make full use of the legal protections regarding his or her admission and retention, one must have knowledge of these rights and of the availability of persons to ensure that these rights are protected. In order for patients and residents to be fully aware of their rights, a manual of patient rights has been developed. Although such an effort will provide a measure of needed assistance to patients, face-to-face contact remains the most effective means of communicating this information, particularly for persons undergoing an acute disruption of their lives. Currently, MHIS is required to perform this informational function, but it could be provided by the clinical or paraprofessional staff of the admitting facility. However, direct contact between the client and MHIS staff would be a more effective and appropriate way of assuring the resident that an agency independent of the Department of Mental Hygiene exists and is readily available to provide assistance to the patient or resident. The direct provision of such informational service by MHIS could

also serve as the first checkpoint for assessing the need for provision of legal assistance to the particular client. It is important that this function be retained by the Service, since its ability to provide legal services to patients or residents is so directly related. This function could readily be performed by legal paraprofessionals.

RECOMMENDATION

MHIS SHOULD CONTINUE TO BE RESPONSIBLE FOR INFORMING PATIENTS OF THEIR RIGHTS RELATED TO THEIR ADMISSION AND RETENTION. THE SERVICE ALSO SHOULD ASSESS LEGAL NEEDS OF CLIENTS NOT DIRECTLY RELATED TO THEIR CARE AND TREATMENT AND MAKE REFERRALS TO OTHER AGENCIES.

4. Assistance to Families

Perhaps the most vague function of the Service is the requirement that it provide services and assistance to families of persons committed to a mental hygiene facility. Family involvement in the care and treatment of a person may be most beneficial to the client and may assist in the successful treatment and discharge of a person from institutional care. The importance of this function to the care and treatment is recognized by the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities by their development of case management systems to provide help to families. This would seem to obviate the need for the Service to provide such assistance to families in most cases. Not only is it unclear precisely what types

of services are contemplated by the statute, but the workload analysis by O.C.A. shows that this function was not even included in the tasks performed by MHIS. These services should be limited to informational services described above and assistance directly related to patient care.

RECOMMENDATION

MHIS SHOULD PROVIDE ASSISTANCE TO FAMILIES ONLY INSOFAR AS IT RELATES DIRECTLY TO PATIENT CARE AND INFORMATIONAL SERVICES.

5. Patient Abuse

Elimination of abuse and mistreatment of patients and residents has been a major purpose of advocacy groups. Legislative and Executive concern over the incidence of patient abuse has resulted in several agencies and officials being charged with the responsibility for investigating patient abuse. The Mental Hygiene Law assigns responsibility for investigating allegations of patient abuse to the Commissioner, the Board of Visitors, MHIS, Commission on Quality of Care for the Mentally Disabled, and the Director of the facility where the alleged incident occurred. The Social Services Law places responsibility on the local child protective service agency to investigate all cases of reported abuse or mistreatment of persons under the age of twenty-one, including those children and adolescents residing at DMH facilities. In the latter case, the Offices of the Department of Mental Hygiene and the Department of Social Services have established procedures for the shared investigation of complaints of abuse or mistreatment.

Unfortunately, the current arrangement confers the identical responsibility upon too many different agencies without a clear assignment of roles to each of the actors and thus often results in the failure of independent oversight of the facility director's primary investigation as intended. Rather than having each of these agencies competing with one another, duplicating each others efforts, or deferring all responsibility to the facility director, their roles should be more clearly defined in order to provide for a system of effective investigation of allegations of patient abuse and independent monitoring of the investigative process.

Primary responsibility for conducting such investigations ought to remain with the facility director since, if the allegations are confirmed and an employee is found to have been involved in patient abuse or mistreatment, the facility director bears the direct and primary responsibility for invoking appropriate disciplinary measures. Permitting independent agencies to usurp this primary responsibility is not only inefficient but may result in inadvertent jeopardy to a successful disciplinary process where one is warranted. Outside investigators, who may not be sufficiently aware of employees' rights under the State collective bargaining agreement, may very well prejudice the case against the employee by failing to respect those rights (see In Mtr. of Contract Arbit. btw. CSEA (William H. Dash) and N.Y. Dept. Ment. Hyg., 2 O.E.R. Grievance and Disc. Arb. 1119 (D. Eischen, Arb., Case No. G-44, November 21, 1975).

The course of the facility director's investigation ought to be monitored by the facility board of visitors and any alleged deficiencies in investigating the incident or commencing a disciplinary proceeding where warranted ought to be reported to the Commission on Quality of Care for the Mentally Disabled for appropriate action pursuant to its residual power to investigate such incidents.

Consistent with the Service's responsibility to serve the residents in mental hygiene facilities, it would be more appropriate for MHIS to represent the legal interests of the resident during the course of the facility director's investigation or that of any other agency. The current responsibility of the Service to investigate allegations of patient abuse or mistreatment results in staff time being devoted to reviewing incident reports, a function commonly performed by the Board of Visitors, as well as the actual investigation of the allegation.

By redefining the Service's responsibility to that of counsel instead of investigator, the interests of the client will be protected more adequately during the investigation. In this capacity, MHIS would serve as an advocate for the patient or resident during the investigation and provide whatever legal assistance or advice may be appropriate. For example, if the clinical records of the patient witness are sought by the employee's attorneys to assist in cross-examination, MHIS should represent the patient's interest in

preserving the confidentiality of such records. Thus MHIS would complement and not duplicate the functions of other independent agencies, as well as provide an important service to the client not now specifically required or provided. Such a change would not require changing the nature of the employee disciplinary process to include the patient as a party, but would provide a patient, who has been either victim or witness to an alleged incident of abuse or mistreatment, access to counsel to represent his legal interests in the proceedings.

RECOMMENDATIONS

MHIS SHOULD BE REQUIRED TO PROVIDE LEGAL ASSISTANCE TO PATIENTS OR RESIDENTS INVOLVED IN AN INVESTIGATION OF ABUSE OR MISTREATMENT AND IN ANY DISCIPLINARY PROCEEDING BETWEEN THE EMPLOYER AND EMPLOYEE RELATED TO SUCH ABUSE OR MISTREATMENT. ITS STATUTORY RESPONSIBILITY TO INVESTIGATE INDEPENDENTLY THESE INCIDENTS SHOULD BE REPEALED.

6. Grievance and Disciplinary Procedures

The Service's responsibility to examine the grievance and disciplinary procedures in safeguarding the rights of patients involved in incidents of abuse and mistreatment and to report its findings to the Legislature is time-limited, but nonetheless, has resulted in several legislative and administrative recommendations. However, the disciplinary and grievance procedures are the result of labor and management negotiation, and any substantive modifications

require Executive consent. This effort would have a greater impact if the Service were authorized to report annually to the Governor and Legislature on this matter.

RECOMMENDATION

MHIS SHOULD BE REQUIRED TO SUBMIT AN ANNUAL REPORT ON THE EFFECTIVENESS OF THE GRIEVANCE AND DISCIPLINARY PROCEDURES TO THE GOVERNOR AND LEGISLATURE.

7. Conditional Release and Voluntary Admission Status

Similar to its court reporting function, is the requirement that MHIS examine persons conditionally released from State facilities, and voluntarily admitted to the facility to determine their suitability and willingness to remain in such a status. If MHIS has any doubts about the client's suitability or willingness to be conditionally released, or remain as voluntary patient or resident it is required to apply for a court order to resolve any questions regarding the client's status. MHIS must notify the director of the facility and the client upon application for court review.

As can be seen from this process, MHIS independently examines and assesses the placement status of the client and reports its findings to the court. It may judge not only the willingness of the client to remain in this status, but his suitability as well. This task may place MHIS in the dubious position of being both representative to the client and court aide. It would be neither justifiable nor ethical for the Service to provide legal assistance to a client who may

want to challenge in court the very findings of the agency representing him. In order for the Service to provide effective legal representation to a client regarding his placement status, the Service cannot be responsible for making an assessment for the court, independent of its client's desires. The review of the client's suitability should be a clinical procedure which the facility director should be required to perform. The Service, however, could remain responsible in a court procedure for representing the client's willingness to be so placed and for obtaining such expert witnesses as may be needed to support the client's case. This would preserve the adversarial nature of the court procedure and thus preserve the client's right not to be deprived of his liberty without due process.

RECOMMENDATION

RESPONSIBILITY FOR ASSESSING SUITABILITY FOR PLACEMENT ON CONDITIONAL RELEASE AND VOLUNTARY ADMISSION STATUS SHOULD BE PLACED ON THE FACILITY DIRECTOR WHILE THE CLIENT'S WILLINGNESS SHOULD BE ADVOCATED BY THE CLIENT'S LEGAL REPRESENTATIVE INCLUDING MHS. THIS CHANGE WOULD BE CONSISTENT WITH THE ADVOCACY RESPONSIBILITIES OF MHS AND WOULD REMOVE THE POTENTIAL ROLE CONFLICT CITED ABOVE.

Staffing

In reviewing these recommendations, it is clear that a greater emphasis is being placed upon the legal services

than the information services performed by MHIS. In order to implement effectively the recommendations, the Service must have appropriate staff to carry out its assigned responsibilities. In most cases, the Service would provide or make available legal services to the mentally disabled, and as such, the employment of lawyers and a paralegal staff is critical.

Among the four departments of the MHIS, it is only in the Fourth Department that such a staffing pattern is a problem. This Department has not hired lawyers but has depended upon the legal resources of the community. Although such collaboration is commendable, the lack of a core legal service in the Fourth Department will seriously impede its ability to provide effective legal services for the mentally disabled.

Another area for examination is the staff needed to inform patients of their rights upon admission. Although the use of lawyers at this stage could begin to establish the "lawyer-client relationship", it would seem preferable to make better use of the lawyer's time. The employment of paraprofessionals, serving as assistants to the legal staff, with proper supervision could effectively transmit to the residents their rights and the availability of the Service for legal assistance regarding their admission and retention, and care and treatment.

Although the staffing needs identified for the Service are legal or para-legal in nature, use of clinicians is

vital to the provision of effective counsel. Rather than hiring a core clinical staff for MHIS of a calibre to equally match the expert witnesses that may be presented by the legal adversaries, appropriations should be specifically authorized to contract for clinical consultants or expert witnesses to assist the legal staff in properly representing the patient or resident.

Critical to the effective utilization of the staff provided to MHIS is the development of a formal continuing education and training program for MHIS staff. Such a training program would be essential in communicating the established priorities and the goals and objectives of the agency Statewide.

RECOMMENDATION

MHIS SHOULD HAVE A STAFF OF LAWYERS AND PARALEGAL PROFESSIONALS TO ENABLE IT TO ADEQUATELY DISCHARGE ITS DUTIES. MHIS SHOULD BE REQUIRED TO ESTABLISH AND MAINTAIN A FORMAL EDUCATION AND TRAINING PROGRAM FOR ITS STAFF.

Organizational Structure

The organizational structure of the Mental Health Information Service has been subject to legislative scrutiny for some time. These deliberations have focused on two issues, organizational placement and management control. In regard to the first issue, two options for placement have

been examined; should MHIS remain within the Judiciary and if so, should it be centralized under the Office of Court Administration, or should it become part of the Executive Department and, if so, where? The second problem of management control involves the accountability of the Service's performance and its coordination with other legal/advocacy groups.

1. Management Control

The first organizational issue which must be addressed is the management of the Service's activities. Historically, this has been limited to debating whether the operations of MHIS should continue to be decentralized or placed under the central control of the Office of Court Administration. However, other fundamental management problems exist which will not be resolved by merely changing the placement of the agency within the Judiciary or even transferring it to the Executive Department. Regardless of the organizational placement of the MHIS, two critical management problems exist which require action. First, mechanisms must be established which will result in greater uniformity of services statewide and greater accountability for the performance of the agency. Second, those activities of MHIS which are similar to or closely related to activities of other legal/advocacy organizations must be more closely coordinated to assure both effective use of resources and elimination of gaps in services and needless duplication of services.

One of the most significant criticisms of the Mental Health Information Service is that it "has not become the Statewide agency as originally envisioned..."(39) As pointed out in the 1973 evaluation of MHIS by the Assembly Ways and Means Committee and as documented in the 1977 workload analysis of MHIS conducted by the Office of Court Administration, regional variations exist in the types of services performed by MHIS and in the type of staff available to serve the needs of the mentally disabled. Although this arrangement provided flexibility in the initial establishment of the agency and in testing different approaches to safeguarding the rights of the mentally disabled, no procedures exist to assess the effectiveness of the diverse approaches or for transforming successful approaches into a permanent organizational structure. The lack of internal accountability of agency performance impedes the ability of the Service, the Office of Court Administration, and the Legislature to make reasonable decisions regarding the effectiveness of current operations and allocation of present resources, and the targeting of any future staffing increases. Although a new uniform statistical report for MHIS, developed by the Office of Court Administration, will be helpful in assessing the types of activities, there remains a critical need to build into the agency a capacity for internal evaluation to review both scope of services as well as outcome.

Terminating the current administrative structure, under which there are four separate MHIS organizations administered by the presiding justices of each of the Appellate Divisions, is not merely desirable, it is constitutionally necessary. In 1977, Section 28 of Article 6 of the New York State Constitution was amended in order to unify and centralize administrative power within the judicial system. Prior to the amendment, Article 6, Section 28 stated that:

"In accordance with the standards and administrative policies established by the administrative board, the Appellate Division shall supervise the administration and operation of the courts in their respective departments." (Emphasis supplied)

The constitutional amendments move this administrative power from the Appellate Division, transferring it to:

"The chief administrator, on behalf of the chief judge, shall supervise the operation of the unified court system."

By virtue of the enactment of this constitutional amendment, administrative authority has been removed from the Appellate Divisions. Thus, the current provisions of Section 29.09 placing administrative authority for MHIS upon the presiding justice of the Appellate Division is inconsistent with the requirements of Section 28 of Article 6 of the State Constitution.

If MHIS is to remain within the judiciary, its administration should be centralized consistent with the constitutional amendment. This, however, does not preclude regional operations if they are determined to be desirable by the chief judge

and the Court of Appeals. Nor does it preclude the delegation of certain administrative functions by the chief judge and chief administrator to the presiding justices.

It is essential that the current fragmented approach to management of MHIS be terminated. There should be strong central direction for MHIS with uniform Statewide goals and objectives. Staff must be trained to understand and appreciate the priorities established for MHIS under central direction as well as the goals and objectives. An internal evaluation mechanism needs to be established to ensure accountability in achieving the established goals and objectives. The continued use of regional offices in each of the Judicial Departments may very well be deemed a desirable practice.

The second management problem of MHIS is the agency's relationship to other legal/advocacy organizations and the coordination of their services. In recent years there has been a major increase in the number of groups providing advocacy services for the mentally disabled. Nationally, the most dramatic change in this field has been the establishment of protection and advocacy systems for the developmentally disabled in every state, and within New York State, the creation of the Commission on Quality of Care for the Mentally Disabled. The potential for further growth of such services is highly likely given the pending creation of protection and advocacy services for independent living as required under P.L. 95-602 ("Rehabilitation Comprehensive Services and Developmental Disabilities Amendments") and the possible

establishment of a similar system for the mentally ill as contained in the amended legislation of President Carter's proposed Mental Health Systems Act (S.1177). With a growing number of individuals, private organizations, and governmental agencies concerned with the quality of care and treatment for mentally disabled citizens, the failure to coordinate such services will only result in competition between these groups or unnecessary gaps in services which will ultimately deprive the disabled of access to a well-organized system of legal/advocacy services. This lack of coordination is illustrated by the discussion of the number of agencies and persons charged with investigating patient abuse (see pp. 40-43).

RECOMMENDATIONS

1. THE CURRENT DECENTRALIZATION OF AUTHORITY IN MHIS SHOULD BE CHANGED TO A CENTRAL MANAGEMENT FOCUS. AS REQUIRED BY THE CONSTITUTIONAL AMENDMENTS THE CURRENT ADMINISTRATIVE AUTHORITY OF THE PRESIDING JUSTICES SHOULD BE TRANSFERRED AND REPOSED IN A CENTRAL ADMINISTRATIVE AUTHORITY. HOWEVER, STRONG CENTRAL MANAGEMENT DOES NOT PRECLUDE THE USE OF A REGIONAL APPROACH TO SERVICE DELIVERY.

This would permit the establishment and implementation of statewide policies and standards for the Service, resulting in greater uniformity and availability of critical services and performance by staff. More specifically, the central administrator should be responsible for:

-promulgating rules and regulations;

- establishing staffing criteria and appointing all personnel; and

- developing the budget for the Service's operations.

2. THE PLACEMENT OF MHIS STAFF IN MENTAL HYGIENE FACILITIES SHOULD CONTINUE SINCE IT ENSURES THAT ADVOCACY SERVICES ARE NOT ONLY AVAILABLE BUT ACCESSIBLE.

3. A GOVERNING BODY SHOULD BE ESTABLISHED AS PART OF THE ORGANIZATIONAL STRUCTURE OF MHIS TO SERVE, IN ESSENCE, AS A BOARD OF DIRECTORS. THIS BODY SHOULD BE COMPOSED OF REPRESENTATIVES OF VARIOUS ADVOCACY ORGANIZATIONS AS WELL AS CONSUMERS OF MENTAL HYGIENE SERVICES AND MEMBERS OF THE LEGAL COMMUNITY. THE PURPOSE OF THIS ENTITY WOULD BE TWOFOLD: TO PROVIDE INTERNAL ACCOUNTABILITY FOR THE ACTIVITIES OF MHIS AND TO ENSURE GREATER COOPERATION BETWEEN MHIS AND OTHER ADVOCACY ORGANIZATIONS. MORE SPECIFICALLY, THE GOVERNING BODY WOULD:

- establish annual goals and objectives for MHIS on a statewide basis;

- develop priorities for the Service's activities based on established goals and objectives;

- assess the effectiveness of MHIS in performing its functions;

- foster the coordination of MHIS activities with other legal/advocacy agencies; and

- review and approve budgetary requests for the operation of the Service to ensure that such requests reflect agency goals and objectives, and performance evaluations.

4. IN ORDER TO PROMOTE COLLABORATION BETWEEN MHIS AND OTHER LEGAL/ADVOCACY ORGANIZATIONS, THE SERVICE MUST HAVE

THE AUTHORITY TO SUBCONTRACT FOR LEGAL AND INFORMATIONAL SERVICES WITH COMMUNITY ADVOCACY AGENCIES.

This would curtail "turf battles" between these groups and, more importantly, increase the accessibility of these services to the mentally disabled.

5. THE SERVICE SHOULD BE REQUIRED TO REFER CLIENTS IN NEED OF LEGAL SERVICES, NOT DIRECTLY RELATED TO THEIR CARE AND TREATMENT, TO OTHER LEGAL SERVICES AGENCIES.

This referral procedure would permit the Service to devote its staff time to legal issues related to patient care, i.e. admission and retention, and abuse or mistreatment. The current authority of the Service to represent mentally disabled persons in all legal proceedings in which they have standing extends its responsibility far beyond capacity and ignores the availability of other legal resources.

2. Organizational Placement

In our judgment, the issue of organizational placement is clearly subordinate to the substantive and internal organizational changes we recommend. In reviewing past legislative efforts to reorganize the MHIS, the proposals have always maintained the Service as an agency independent of the Department of Mental Hygiene. Although the bills that have been introduced to reorganize the Service generally have retained the Service in the Judiciary, transferring the agency to the Executive Department has been recommended. The latter proposal would have resulted in establishing an independent State

agency in the Executive Department. The Service could be established as a component of a comprehensive advocacy agency, or it could be placed within the Commission on Quality of Care for the Mentally Disabled. These various options have both strengths and weaknesses which deserve careful consideration in selecting the appropriate governmental structure for the management of the Service's operations.

Before examining the issues associated with the specific options, there are general problems associated with placement in the Executive Department and the Judiciary which require elaboration.

One of the principal arguments for transferring MHIS from the Judiciary to the Executive Department is that such an arrangement would relieve the Judiciary from overseeing an operation which is not directly related to the ongoing operations of the court system. Just as conflicts have been cited in the Service's responsibility to both represent patients and yet assist the courts, a similar appearance of conflict exists for the Judiciary to provide both the arbiters of legal disputes and legal advocates for one of the parties to such disputes.

Another argument, advanced by some fiscal analysts, is that removal of MHIS from the Judiciary may enhance the possibility of obtaining medicaid reimbursement for some of the services provided, thus reducing the State's expenditures for the support of MHIS.

Although such a transfer would remove the Judiciary's administrative responsibility to manage a legal advocacy service, an operation not traditionally considered a function of the court system, it has been argued that the transfer would adversely effect the independent operation of the Service. Since MHIS is empowered to provide legal services to the mentally disabled, the agency may bring legal actions against Executive branch agencies when the policies of the State conflict with a client's interest. Placing the Service in the Executive Department may create the perception that the agency does not have the independence to effectively serve as a legal advocate. It has also been argued that such a transfer would subject the MHIS's budget to greater Executive control, a consequence which could effectively endanger its independence.

In reviewing the three options for placement of the Service in the Executive Department, there are other unique factors to each option which require examination.

(1) Independent Agency

Establishing the Service as an independent State agency in the Executive Department would remove the appearance of conflict within the Judiciary and would provide MHIS with a degree of autonomy that it would not have as a component of another Executive Department agency. This would become the basis for unified and comprehensive legal advocacy services for the mentally disabled throughout the State and,

as such, enable the Service for the first time to be viewed as a single State agency rather than an incidental operation of the Judiciary.

However, the establishment of such a new agency could also further complicate the problem of coordinating existing State agencies or State-designated authorities which provide advocacy services to the mentally disabled (included among these are the Commission on Quality of Care for the Mentally Disabled, Boards of Visitors, Office of Advocate for the Disabled, and the Protection and Advocacy System for the Developmentally Disabled). This problem could be minimized since the primary responsibility of the Service under this proposal would be as a personal legal representative to a mentally disabled person. As such, this function clearly differentiates the Service from all other existing Executive Department agencies, which do not assume such a role.

(2) Within the Quality of Care Commission

The transfer of MHIS to the Commission could be viewed as establishing a comprehensive advocacy and oversight agency responsible for defending the rights of the mentally disabled and monitoring the operations of the Offices of the Department of Mental Hygiene; however, there are various practical and substantive problems with this approach.

This option would present management problems for the Commission affecting its ability to adequately fulfill its other statutory functions. Management and organizational

problems would occur if MHIS, an agency with a budget triple that of the Commission, were grafted onto the Quality of Care Commission. Such a change would severely hamper the current operations of the Commission, and would dramatically alter its priorities.

Both the Service and the Commission can be termed "advocacy" agencies for the mentally disabled; however, closer scrutiny would reveal that the nature of the respective advocacy functions differs significantly. For example, in investigating allegations of patient abuse and mistreatment, the Commission functions in a quasi-judicial capacity and has a responsibility to make findings which may be contrary to the allegations of a patient or resident in appropriate circumstances. The Service, in the tradition of legal advocacy, would be compelled to represent the legitimate interests and assert the particular desires of the patient even if they are contrary to the findings of the Commission, or the decisions or policies of other State agencies.

Thus, the Service and the Commission would be placed in an awkward and difficult situation in such circumstances.

There are possible administrative structures to ameliorate such conflicts, such as the manner in which staff to the Public Service Commission independently operate (see Section 124(2), Public Service Law). However, this is both a unique and cumbersome solution and one which would require a significant restructuring of the Commission.

(3) Public Advocate Office

The third option for placement in the Executive Department is the creation of a new office to serve as public advocate. A comprehensive advocacy agency would be established under this option to serve the citizens of this State, and thus place New York's extensive advocacy services within a single agency. The most salient benefit to this option is the coordination of diverse public interest advocacy services being performed by various State agencies.

In establishing such an agency, the most difficult task would be the identification of units within State agencies, and State agencies whose principal function is public advocacy. Although this would require an intensive analysis of agency functions, potential components of this Public Advocate Office could include the following:

- Consumer Protection Board which represents the interests of consumer (now in the Executive Department);
- Mental Health Information Service;
- Prisoners Legal Services which is a not-for-profit corporation which provides legal services to inmates (now in the Office of Court Administration);
- Law Guardians which provide legal counsel to minors in Family Court proceedings (now an operation of the Appellate Divisions);
- Assigned Counsel which provide legal services to indigents and wards of the State (now an operation of the Appellate Divisions); and
- Office of Advocate for the Disabled which is responsible for enhancing the understanding of the problems of the disabled (located in the Executive Department).

The feasibility of this planned approach to advocacy has been demonstrated successfully in New Jersey, although on a much smaller scale, where a Department of Public Advocate (DPA) was created in 1974. The DPA has the following units:

- Division of Public Defender to represent indigents charged with criminal or juvenile offenses;
- Office of Inmate Advocacy and Parole Revocation to provide civil representation for jail and prison inmates;
- Division of Mental Health Advocacy to represent indigent persons during commitment proceedings;
- Division of Rate Counsel to represent the public interest in utility and other rate hearings;
- Division of Public Interest Advocacy to represent the public in any proceedings in which the public interest is not adequately represented; and
- Division of Citizen's Complaints and Dispute Settlement to receive and forward citizen complaints to appropriate State agencies for action, and to investigate allegations of improper action.

Although the establishment of a comprehensive advocacy agency would promote greater oversight of funds allocated to public interest advocacy and would increase accountability on the part of those persons working for the public interest, the process required for a careful assessment of ongoing advocacy services would preclude any imminent change in the structure and functioning of MHIS. In addition, this option could hinder the development of an effective statewide system of advocacy for the mentally disabled given the divergent efforts that would be undertaken in such an agency.

This could result not only from establishing other advocacy services as a priority over MHIS, but also from the potential to administratively transfer resources of the Service to other components of the public advocacy agency. As such, this option not only would be very time consuming in implementing, but could severely hinder the effectiveness of the Service in advocating for the rights of the mentally disabled.

RECOMMENDATION

IN SUMMARY, THE ORGANIZATIONAL PLACEMENT ISSUE IS CLEARLY SUBORDINATE TO THE CLARIFICATION OF THE LEGAL FUNCTIONING OF MHIS AND TO THE STRENGTHENING AND UNIFICATION OF ITS INTERNAL MANAGEMENT STRUCTURE.

ALL THE ORGANIZATIONAL PLACEMENT OPTIONS, INCLUDING THE EXISTING ONE, HAVE THEIR STRENGTHS AND WEAKNESSES. WE RECOMMEND THAT THE EXECUTIVE, LEGISLATIVE AND JUDICIAL BRANCHES OF GOVERNMENT WEIGH THE OPTIONS IN DETERMINING WHAT CHANGE, IF ANY, IN THE ORGANIZATIONAL PLACEMENT OF MHIS SHOULD BE MADE IN THE INTEREST OF BETTER SERVING THE NEEDS OF THE MENTALLY DISABLED.

FOOTNOTES

1. Testimony of Clarence J. Sundram before the Senate Standing Committee on Mental Hygiene and Addiction Control. Senator Frank Padavan, Chairman (June 21, 1978).
2. The Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York in cooperation with the Cornell Law School, 14 (1962) [hereinafter cited as Mental Illness and Due Process, Report and Recommendations on Admission to Mental Hospitals Under New York Law].
3. Gupta, New York's Mental Health Information Service: An Experiment in Due Process, 25 Rutgers Law Review 405, 412-13 (1971).
4. Mental Illness and Due Process, 86.
5. Id., 20-21.
6. Id., 21-22.
7. Laws of 1964, Ch. 738.
8. Message of the Honorable Nelson A. Rockefeller, Governor of the State of New York, entitled "Mental Hospitals-Admission, Retention and Discharge of Patients," (April 22, 1964).
9. The Judiciary Budget Request for the Mental Health Information Service, Amount Appropriated for Previous Year, Executive Budget Request, Fiscal Year 1966-1967, 674-676.
10. Law's Labor Lost, 40 Psychiatric Quarterly 150, (1966).
11. See Rosenzweig, Compulsory Hospitalization of the Mentally Ill, 61 American Journal of Public Health 125, n. 9 (1971).
12. Gupta, supra at 417.

This variation has been attributed to the lack of clear statutory direction regarding personnel requirements. As noted by Raj K. Gupta:

"The Mental Hygiene Law is silent as to the qualifications MHIS staff should possess. Appointment authority rests in the presiding justice of the appellate division in each of the four judicial departments, and it is he, in agreement with the commissioner of mental hygiene, who determines qualification standards."

13. 15th Judicial Conference Report, 1979, 73-74.
14. Gupta, supra at 449-450.
15. Id., 415, 433.
16. Schneider, Civil Commitment of the Mentally Ill, 58 Journal of the American Bar Association 1063 (1972).
17. Murphy, T.J., The Mental Health Information Service: A Program Review and Suggestions for Reform, (unpublished) New York State Assembly Ways and Means Committee memorandum, July 31, 1973) 12, [hereinafter cited as MHIS Program Review].
18. 12th Judicial Conference Report, 1967, 60.
19. Id., 60-61.
20. Rosenzweig, Mental Health Information Service, A Review of Rules and Regulations, 175 New York Law Journal 1 (1975).
21. Id., 4.
22. Memorandum from E. David Wiley, Counsel to the New York State Department of Mental Hygiene to the Honorable Robert R. Douglas, Counsel to the Governor, (Subject: Mental Hygiene Legislative Proposal No. 6, September 29, 1967) 2.
23. 1969 New York State Legislative Manual, 324.
24. United States ex rel Schuster v. Herold, 410 F. 2d 1071, (2d Cir. 1969), cert. denied 396 U.S. 847 (1969).
25. Memorandum in Support of Senate bill 9088-A by Senator John R. Dunne, entitled "AN ACT to amend the mental hygiene law, in relation to the use and management of institutions in the state department of correction, and to repeal certain sections in relation thereto, and to repeal sections of such law applicable to sentences imposed for offenses committed on or after September first, nineteen hundred sixty-seven," (1970 Session of the New York State Legislature).
26. Laws of 1972, Ch. 251.
27. Laws of 1976, Ch. 334.
28. Id.

29. The issues covered by other legislation which have not passed both houses include the following:
- Notification of MHIS prior to the transfer or change in status of any patient under 21 years of age;
 - Notification of MHIS that a defendant is to be examined for mental illness and it is to provide assistance to such persons;
 - Appointment and removals of MHIS staff and directors to be made by the State Administration of the Office of Court Administration;
 - Notification of MHIS when a prisoner is transferred from a jail to a hospital with a psychiatric prison ward;
 - MHIS to be notified by the director of a DMH facility within 48 hours after a complaint of patient abuse or mistreatment has been made;
 - DMH facility director must notify MHIS of the results of his investigation into allegations of patient abuse incidents;
 - Patients to give consent to any provision of a treatment plan which interferes with his right to communicate, and that if patient is unable to grant consent, MHIS may do so;
 - Service must maintain the confidentiality of records and release them only as provided for by law; and
 - Incident reports be served upon MHIS within 48 hours, or if a death is involved within 24 hours.
30. Message of Disapproval, "To Amend the Mental Hygiene Law, in Relation to the Appointment of the Head of the Mental Health Information Service," (July 21, 1965) in The Public Papers of the Honorable Nelson A. Rockefeller, Governor of the State of New York, (1965), 560.
31. Senate bill 6896, sponsored by Senator James H. Donovan, 1975 Session of the New York State Legislature.
32. Memorandum (re: S.6896) from Howard A. Rubenstein, State of New York Office of Employee Relations to the Honorable Judah Gribetz, Counsel to the Governor (August 1, 1975).
33. New York State Legislature Report of the Senate Finance Committee and the Assembly Ways and Means Committee on the 1973-74 Executive Budget 75.

34. Press Release (Proposed Budget Reductions, 1974-75) issued by Senator John J. Marchi, Chairman, Senate Finance Committee; and Assemblyman Willis H. Stephens, Chairman, Assembly Ways and Means Committee (March 20, 1974) 96.
35. New York State Office of Court Administration "Analysis of MHIS Workload Trends" (November 22, 1977) 4 [hereinafter cited as "Analysis of MHIS Workload Trends"].
36. New York State Legislature, Report of the Fiscal Committees on the Executive Budget, Fiscal Year April 1, 1979 to March 31, 1980, State of New York 118.
37. "Analysis of MHIS Workload Trends," Appendix C, i-v.
38. Speech by Jerome Shestack, Chairman, ABA Commission on the Mentally Disabled, "The Mentally Disabled-A New American Bar Association Viewpoint," (February 2, 1974) in Carnahan and Zusman, Mental Health: New York Law and Practice (1976) at I.10-I.13.
39. MHIS Program Review, 16.
40. Message of the Honorable Hugh L. Carey, Governor of the State of New York, entitled "Mental Hygiene-State Commission on Quality of Care for Mentally Disabled-Creation," (August 1, 1977).

A P P E N D I X E S



*APPENDIX A

PROFESSIONAL STAFF OF MHIS

	<u>GRADE</u>	<u>FIRST</u>	<u>SECOND</u>	<u>THIRD</u>	<u>FOURTH</u>	<u>TOTAL</u>
Director		1	1	1	1	4
Deputy Director	30	1		1	1	3
Planning Officer	32		1			1
Principal Attorney	30	1	3			4
Senior Appellate Law Assistant	28		1			1
Associate Attorney	27	2	5			7
Senior Attorney	25	3	15	1		19
Attorney	22	6	9	3		18
Assistant Attorney	20	9	17	1		27
Principal Information Officer	26			2	3	5
Senior Information Officer	24				2	2
Information Officer	19	4		3	11	18
Counselor	19	1	1			2
Information Assistant	15		1			1
TOTAL STAFF		28	54	12	18	112

Information has been derived from the "Schedule of Positions, 1979-80", Effective December 7, 1979.

ADMINISTRATIVE STAFF OF MHIS

	<u>GRADE</u>	<u>FIRST</u>	<u>SECOND</u>	<u>THIRD</u>	<u>FOURTH</u>	<u>TOTAL</u>
Administrative Services Clerk	20	1	1			2
Secretarial Assistant	15	2	4			6
Secretary	14			1		1
Principal Stenographer	12	8	7		1	16
Senior Stenographer	9		29	3	10	42
Stenographer	5		1	2		3
Typist	4		1			1

TOTAL STAFF		11	43	6	11	71
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TOTAL MHIS STAFF

Professional	28	54	12	18		112
Administrative	11	43	6	11		71

TOTAL STAFF		39	97	18	29	183
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APPENDIX B

The Judiciary
Appropriations For MHIS
Fiscal Years 1965-66 Through 1977-78

Judicial Department	Fiscal Year 1965-66	1966-67	1967-68	1968-69	1969-70	1970-71	1971-72	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78
First		\$193,836	\$212,602	\$214,057	\$241,765	\$294,604	\$323,651	\$350,880	\$588,528	\$661,192			
Second		353,678	387,091	375,368	423,395	521,527	573,065	619,068	1,332,797	1,548,500			
Third		93,146	109,483	108,491	122,627	146,654	133,591	146,360	228,023	294,621			
Fourth		168,520	182,013	183,542	206,153	213,839	232,060	241,060	397,679	450,147			
Total	(1) \$754,000	\$809,180	\$891,189	\$881,758	\$993,940	\$1,176,624	\$1,262,367	\$1,357,368	\$2,547,027	\$2,954,460	(2) \$2,898,190	(2) \$2,833,094	(2) \$3,060,071
Less: Savings								32,407	110,000				
Total (3) Appropriation	\$754,000	\$809,180	\$891,189	\$881,758	\$993,940	\$1,176,624	\$1,262,367	\$1,324,961	\$2,437,027	\$2,954,460	\$2,898,190	\$2,833,094	\$3,060,071

(1) Annualization of part-year appropriation of \$440,000.

(2) Total appropriation only available.

(3) Total appropriations from State of New York, Classification of Appropriations.