Involuntary Interventions In Protective Services for Adults

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I. Goals of Workshop

A. Understanding and intervening in involuntary interventions.
B. Working in a legal, ethical and effective manner - with involuntary individuals and families
C. Options for involuntary interventions in New York State.
D. Indications and contraindications for involuntary action
E. Ethical dilemmas in involuntary actions
F. issues of capacity
G. Case examples
H. Dealing with the aftermath: practical advice and survival strategies for “involuntary intervention practitioners: in PSA “

II. Involuntary Measures in Social Work Practice

A. Self Determination. Social workers respect and promote the right of clients to self determination and assist clients in their efforts to identify and clarify their goals. Social workers may limit clients’ right to self determination when, in the social worker’s professional judgment, client’s actions or potential actions pose a serious, foreseeable and imminent risk to themselves or others.

B. Commitment to Clients. Social workers’ primary responsibility is to promote the wellbeing of clients. In general, clients’ interests are primary. However, social workers’ responsibility to the larger society or specific legal obligations may, on limited occasions, supersede the loyalty owed clients, and clients should be so advised.

C. Clients Who Lack Decision Making capacity. When social workers act on behalf of clients who lack the capacity to make informed decisions, social workers should take reasonable steps to safeguard the interests and rights of those clients.

D. Value: Competence
Ethical Principle: social workers practice within their areas of competence and develop and enhance their professional expertise.

Social workers continually strive to increased their professional knowledge and skills and to apply them in practice.

III. Guidelines for Ethical Practice

A. Client perspective: It is critical to consider the client perspective on his or her circumstances to determine whether involuntary interventions can be avoided and what actions would constitute ethical and humane methods to preserve client safety. Being aware of or addressing the following issues with clients may also help APS clients move in the direction of accepting service voluntarily.

i. Loss of control – does the proposed remedy or intervention infringe on the client’s sense of control over his or her life or environment? Can the client be involved in any way in decision making about implementation of the intervention to retain some sense of control?

ii. Intrusion on civil rights – Clients have a right to self-expression, to freedom of association, to mobility, to make lifestyle choices. To what extent does the proposed intervention curtail a client’s civil rights that are exercised by others without interference? What are the minimal restrictions that need to be exercised to preserve safety?

iii. Loss of autonomy - related to i. and ii. – Clients have a right of self-determination. What is the rationale for narrowing the area of autonomy in which a client can operate independently without restriction? What decision making can be retained by the client without compromising health or safety?

iv. Lack of urgency – Professionals may see the client’s situation as urgent; e.g., hoarding behaviors constitute a health and safety hazard for the client and perhaps the neighborhood, but in the eyes of the client current conditions are normal and comfortable. Clients often do not share the urgency felt by those around them to make changes in their circumstances. The lack of urgency may result from complacency, “thinking errors” resulting from dementia or mental illness or from fear of making a change. Addressing the underlying feeling may help the client accept change in gradual steps. Negotiation is also in order to test how far the client will go voluntarily to make changes (e.g., accept one visit with a mental health professional, work on clearing out one area of the house to create a clean and uncluttered place to sleep).

B. Why is this intervention necessary? – The answer to this question determines the goals of the intervention and also may determine the type of intervention.

i. Imminent danger? -- This is the gold standard for involuntary intervention. If the answer is affirmative, then the situation merits a plan of immediate intervention. The possibilities for addressing risk factor should be reviewed to choose the least restrictive measure. (e.g., call to 911 vs. negotiation with client about temporary placement in a shelter or respite bed.)
ii. Health/safety issues? - How is the risk to the client defined? Involuntary intervention should be used only when there is an active threat to the client’s health and safety (or to client resources needed to maintain safety and wellbeing.)

iii. Unpopular/unappealing lifestyle or behaviors? – Was the case referred only because the client is engaging in behaviors that are unpopular or unappealing to family members or neighbors? Is the client exercising a right to make bad decisions or conduct himself in ways that make him/her unpopular but that really don’t place the client at risk?

C. Consequences of inaction – What would be the impact of doing nothing? Is there liability for the PSA unit and county government as well as for the client? Will APS be cited for unprofessional and negligent conduct if involuntary action is not pursued?

D. Inability (on part of PSA client) to understand consequences – this is an essential assessment that must be made by PSA. If a client clearly understands the consequences of their actions and choices, PSA is severely limited in what involuntary actions may be taken. (MHL Article 81 Guardianship will be ruled out if the client understands the “consequences of their functional limitations” and refuses services.)

E. Will the intervention achieve the intended objective? – The intervention must be tailored to the service plan objective.

F. Capacity issues and evaluation – PSA must always keep in mind the issue of client capacity. Does the client have the capacity to make critical decisions? Does he or she understand the consequences of refusing medical care, not taking hypertension medication, refusing to clear out excessive clutter, allowing family members to use funds needed for rent, etc. If capacity is not clear, PSA needs to arrange for a capacity evaluation by a mental health professional.

* Intermittent capacity or ‘focused’ capacity – capacity may not be consistent or operative in all areas. Clients with dementia may be “clearer” in the morning or may have capacity in some areas but not others.

IV. Principles of Involuntary Intervention

A. Least restrictive measure – Principles of ethical social work practice require that when considering involuntary interventions the least restrictive measure to correct the problem should be applied.

C. Surrogate decision making – In cases in which PSA is acting as a surrogate decision maker (MHL Article 81 guardianship; SCPA 17a guardianship).

i. Client’s preferences chosen whenever possible – PSA needs to determine client wishes in critical areas such as healthcare decisions, lifestyle choices, end of life decision making.

ii. Substituted judgment – this principle applies when PSA is acting as surrogate decision maker. PSA should make decisions that mirror the decisions the client would make on his/her own provided client wishes are known.
iii. Best interests of client – The principle of best interests of the client should apply in all decision making when the client’s own wishes are not known.

**V. Assessment of Diminished Capacity**

A. Presumption of Capacity – clients are presumed to have capacity to make decisions until a formal assessment or a court determines otherwise.

B. Capacity “domains” – capacity is not necessarily global. Capacity can be confined to certain areas, such as healthcare decisions versus financial decisions; testamentary capacity versus end of life decision making.

C. Cultural considerations – The client’s cultural context is important to consider. The client’s decisions may be determined by cultural values rather than by issues of diminished capacity. What role does the client’s faith tradition play in decision making?

D. Role of ageism – To what extent are assumptions about age and decision making operating in the assessment of client’s ability to make decisions? Is advanced age being confused with lack of ability to make reasoned choices?

E. Role of undue influence – use of role and power to manipulate the decision making of another.

*“Induced vulnerability”* - In recent years, the subject of undue influence has received increasing attention in the field of elder abuse prevention. Simply stated, undue influence is when an individual who is stronger or more powerful gets a weaker individual to do something that the weaker person would not have done otherwise. The stronger person uses various techniques or manipulations over time to gain power and compliance. Inducing someone to sign a legal document or give a gift, for example, may constitute abuse if the person does not fully understand the transaction, appreciate the value of what they are giving away, or comprehend the implications of what they are doing. Was coercion, trickery, or undue influence employed?

F. Impaired Executive Function - Executive function is an umbrella term for cognitive processes such as planning, working memory, attention, problem solving, verbal reasoning, mental flexibility, multi-tasking, organizing of processes. Recent research has focused on impairment of mental functioning related to the discernment of factors and the planning of activities regarding critical decisions. Executive function impairment may be associated with frontotemporal dementia or with a number of psychiatric and developmental disorders.

G. Identifying sources of diminished capacity/bolstering capacity – a variety of factors may influence capacity including physical health, mental health and environmental factors. PSA needs to keep in mind that physical conditions such as poor nutritional status and urinary tract infections can affect cognition and capacity. Dementia and mental health conditions such as depression and anxiety can interfere with capacity. PSA should also assess for sensory impairments such as hearing and vision problems that can interfere with the capacity to make informed choices. All of these factors have the potential to be
remedied if not eliminated through medication, medical treatment, hearing aids, etc. which may “bolster” capacity to make decisions.

VI. Involuntary Services and Interventions under Protective Services for Adults (PSA)

A. “When the district believes that there is a serious threat to an adult’s wellbeing and that the adult is incapable of making decisions on his or her own behalf because of mental impairments, the social services official has a responsibility to pursue appropriate legal interventions... even though such interventions may be against the wishes of, or without the knowledge of, the adult at risk. The district must employ the least restrictive intervention necessary to effectively protect the adult.” 18 NYCRR section 457.6.

B. PSA itself has no power to remove persons from the home or other location, or to take any voluntary action. PSA must request such authority or such action from others who can take or authorize such action.

C. Orders to Gain Access

PSA/the local district may apply to the supreme or county court for an order to gain access to a person to assess whether such person is in need of PSA, when the PSA caseworker, having reasonable cause to believe that such person may be in need of PSA, is refused access by such person or another individual. If access has been refused, PSA must make prompt and continuous efforts to obtain access voluntarily before seeking an order to gain access. The order authorizes assessment only, and can be sought on an ex parte basis. Social Services Law section 473-c.


Order granting county social services department access to home of individual believed to be in need of adult protective services was not required to be served on individual prior to its execution.

D. Crisis Interventions

State law contains several specific interventions that can be utilized in crisis situations, meaning situations in which there is an immediate and identifiable danger to a person or his or her property. If the person, because of an impairment, is incapable of making the choices necessary to remove the endangering condition, the following interventions can be used to address crises:

i. Short-term Involuntary Protective Services Orders (STIPSO)

When an adult is at imminent risk of death or serious physical harm, is unable to understand the risk because of an impairment, and is refusing services, PSA may apply to the supreme or county court for authority to provide involuntary emergency services for a 72-hour period, with one renewal for an additional; 72 hours. The person may be removed to a hospital or receive other services available
through PSA. However a STIPS0 may not be used for an involuntary admission for mental health services. Social Services law section 473-a.

**ii. Civil commitment under Mental Hygiene Law (MHL) Article 9**

Social services officials (local DSS commissioners) are charged with the duty of seeing that mentally ill person within their respective communities who are in need of care and treatment at a psychiatric hospital are admitted to a hospital pursuant to the provision of article 9 of the MHL. Such officials must notify the director of community services of any such person coming to their attention. MHL section 9.47

PSA/district may apply for:

- An involuntary admission on medical certification of two examining physicians (the so-called “2 PC”) for any person alleged to be mentally ill and in need of involuntary care and treatment. The application is made to a director of a psychiatric hospital. MHL section 9.27.

The term “in need of involuntary care and treatment” means that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person’s welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment. MHL section 9.01.

Although this statute does not expressly require that the person also a danger to himself or others, both federal and state case law have required the element of a danger to self or others for involuntary admission. O’Connor v. Donaldson, 422 U.S. 573 (1975); Project Release v Prevost, 722 F.2d 960 (2d Cir, 1983); In re Harry M, 96 A.D.2d 201 (2d Dep’t 1983); Scopes v Shah, 59 A.D.2d 203 (3Dep’t 1977)

Other involuntary provisions include:

- Involuntary admission on certificate of a director of community services or designee for any person found by such official to have a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. MHL section 9.37.

The term “likely to result in serious harm” means (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. MHL section 9.01.

- Emergency admissions for immediate observation, care and treatment, upon a finding by a staff physician of a hospital that a person has a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to self or others. MHL section 9.39.
• Emergency admissions for immediate observation, care and treatment; powers of certain peace officers and police officers. A peace or police officer may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. The officer may remove the person to a hospital, comprehensive psychiatric emergency program (CPEP) or, pending examination or admission, in another safe and comfortable place, in which case the director of community services or other designated official shall be immediately notified. MHL section 9.41.

• Emergency admissions for immediate observation, care and treatment; powers of court. A court may order that a person before the court who appears to have a mental illness which is likely to result in serious harm to himself or herself or others, be removed to a psychiatric hospital or CPEP for a determination by the director of such program whether the person should be retained for care and treatment. MHL section 9.43.

• Emergency admissions for immediate observation, care and treatment; powers of directors of community services. A director of community services may order removal of a person to a psychiatric hospital or a CPEP upon a report that a person has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. It shall be the duty of a police or peace officer, or upon request, an ambulance service, to transport any such person. MHL section 9.45.

• Emergency admissions for immediate observations, care and treatment; powers of qualified psychiatrists. Similar authority as is described above for directors of community services. MHL section 9.55.

• Emergency admissions for immediate observations, care and treatment; powers of emergency room physicians. Similar authority as described above. MHL section 9.57.

• Assisted Outpatient Treatment (AOT). A social services official is among the many persons eligible to petition a court for an order authorizing AOT. A person may be ordered to receive AOT if the court finds that such person:

(1) is 18 years of age or older; and

(2) is suffering from mental illness; and

(3) is unlikely to survive safely in the community without supervision, based on a clinical determination; and

(4) has a history of lack of compliance with treatment for mental illness that has:

(i) prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or
(ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious violent behavior towards self or others or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any current period, or period ending within the last 6 months, in which the person was or is hospitalized or incarcerated; and

(5) is, as a result of mental illness, unlikely to voluntarily participate in outpatient treatment that would enable him or her to live safely in the community; and

(6) in view of his or her treatment history and current behavior, is in need of AOT in order to prevent a relapse or deterioration which would likely to result in serious harm to the person or others; and

(7) is likely to benefit from AOT.

MHL section 9.60.

(iii) Involuntary admission to a “school”, meaning the in-patient service of a developmental center or other residential facility for individuals with developmental disabilities under the jurisdiction of the Office for People With Developmental Disabilities. A social services official, among others, may apply to the director of a Developmental Disabilities Services Office for the involuntary admission of a person who has a developmental disability and is in need of involuntary care and treatment, subject to the review of two examining physicians or one examining physician and one certified psychologist. MHL section 15.27.

(iv) Orders of Protection

PSA will assist an adult to apply, or apply on his or her behalf to family or county court for an order of protection to control abusive or criminal acts between family members or people in the same household. The order may instruct a person, for example, not to hit the client, or to stop interfering with the delivery of necessary services, such as home care. A person may be ordered to participate in a counseling or substance abuse treatment program (Family Court Act, Article 8.)

Guardianship

• Guardianship (New York Mental Hygiene Law, Article 81)

Vs.

• Guardianship of the Developmentally Disabled and Mentally Retarded (Surrogate Court Procedure Act, Article 17-A)
**PSA must petition the courts when long-term management of impaired person and/or their property is required and no one else is willing and able to assist responsibly.**

McKinney's Mental Hygiene Law § 81.06

Who may commence a proceeding

a) A proceeding under this article shall be commenced by the filing of the petition with the court by:

6. a person otherwise concerned with the welfare of the person alleged to be incapacitated. For purposes of this section a person otherwise concerned with the welfare of the person alleged to be incapacitated may include a corporation, or a public agency, including the department of social services in the county where the person alleged to be incapacitated resides regardless of whether the person alleged to be incapacitated is a recipient of public assistance;

**Supreme Court, Kings County, New York. In the Matter of the Application of SCHWARZ, Petitioners, for the Appointment of a Guardian of Samuel Schwarz, No. 100128/10.Sept. 23, 2011**

The case law has consistently established that even if incapacity is established, a guardian is to be appointed only as a last resort and in a manner which is the least restrictive form of intervention. Such an appointment may be obviated where the alleged incapacitated person have effectuated plans for the management of their affairs and are possessed of sufficient resources to protect their well-being. Such resources have been defined to include a **power of attorney**, health care proxy, and/or a home health aide. (MHL § 81.03(e)).

Motion to dismiss granted


Where the proposed guardian has a conflict of interest or acrimony exists between the proposed guardian and other family members, the court will likely appoint a neutral third party. (the court appointed a neutral guardian with power to manage the concededly incapacitated mother's financial affairs, and a limited guardian of the person to monitor the daughter health care agent in light of a conflict between son and daughter, and the daughter's violation of her fiduciary duties pursuant to a power of attorney)


In *Doar*, APS brought the guardianship proceeding after investigating a landlord's claim that the alleged incapacitated person was refusing to allow the landlord to make repairs. An evaluation of the alleged incapacitated person revealed a 95 year old woman who lived alone, was meeting her
needs, and where she suffered limitations, was compensating in suitable ways. The court concluded that APS had not provided evidence to meet the criteria for incapacity, namely, an inability to understand the nature and consequences of her situation, and declined to speculate about hypothetical events which might place her in jeopardy. In the midst of the guardianship proceeding, APS also sought an order of access to re-evaluate the respondent. The court denied the application on the grounds that APS already had the opportunity to evaluate her, that an order of access was not necessary because the woman regularly left her apartment, and the evaluation would be inappropriate effort to salvage a case that was over 9 months old.


As part of its efforts to protect the alleged incapacitated person, APS also may seek a temporary stay of an eviction proceeding against a tenant


The appointment of the Department of Social Services as the guardian may be the appropriate or only solution in cases where family and friends are not available or willing to act as guardian. When the Commissioner guardian sought the expansion of certain powers, the court granted the relief “but also mandated that the DSS Commissioner personally visit respondent four times per year.” The appellate division modified the order and directed that the Commissioner's obligation as guardian to visit the incapacitated person 4 times a year as mandated by Mental Hygiene Law § 81.20 could be delegated to staff. The court pointed out that the Commissioner is ultimately responsible for the conduct of the staff and thus accountable as guardian. The court also noted that to render the Commission's obligations as guardian as personal rather than “ex officio” would require the modification of each order of appointment when a new Commissioner came into office.

*Matter of Commissioner of Cayuga County Department of Social Services (Bessie C.), 225 A.D.2d 1029, 639 N.Y.S.2d 768 (4th Dept., 1996)*

Potential conflict of interest that exists in appointing the Department of Social Services as guardian. In *Bessie C.*, the local department of social services petitioned the court to be named guardian, most particularly for purpose of gaining authority to exercise the alleged incapacitated person's right of election against her deceased husband's estate.

After considering the factors set forth in § 81.19 as the criteria of eligibility of the proposed guardian, the appellate court concluded that a department of social services which was seeking to recover money from person on public assistance had a conflict of interest in this situation and should not be appointed guardian of the property. The court reversed the decision of the trial court that had denied the son's cross-petition to be appointed guardian of the person and remanded the matter for the appointment of a “neutral, disinterested person” as special
guardian to exercise the right of election and a “neutral, disinterested person” to manage the property.


Doctrine of Substituted Judgment Article 17-A vs. MHL Article 81

The factors enumerated in Mental Hygiene Law § 81.21 (d) are relevant in making such a determination. New York common law has evolved, displacing the arcane philosophical logic that allowed application of substituted judgment only to transactions on behalf of persons who were once capable of handling their own affairs, but not on behalf of persons, like the ward here, who never had that capacity.

**In the Matter of the Application of Northern Manhattan Nursing Home, Petitioner, for the Appointment of Person and Property of A.M. 32 Misc.3d 754, 928 N.Y.S.2d 810, 2011 N.Y. Slip Op. 21247 April 26, 2011.; Supreme Court New York County**

In matter brought by emergency order to show cause, guardian of 92-year-old nursing home resident moved for order authorizing it, as guardian of person and property of incapacitated person, to act on his behalf in withholding consent to his intubation with Percutaneous Endoscopic Gastronomy (PEG) feeding tube, to diagnostic testing, and to medical treatment of metastasized cancer, and further authorizing it to act on his behalf in granting consent to palliative and/or hospice care, and in executing orders of Do Not Resuscitate (DNR) and Do Not Intubate (DNI).

**Power of Attorney Changes**

On September 1, 2009 (further modified effective 9/1/2010) significant changes to powers of attorney took effect designed to prevent the abuse of powers of attorney

One of the most important changes was the allowance of special proceedings to review the validity of the power of Attorney and to review the actions of the Agent; General Obligations § 5-1510

**In the Matter of Walter K.H., Petitioner for the Appointment of a Guardian of the Person and Property of Rosalie H. 2011 NY Slip Op 50969U; SUPREME COURT OF NEW YORK, ERIE COUNTY**

The relationship of an attorney-in-fact to his principal is that of agent and principal and, thus, the attorney-in-fact must act in the utmost good faith and undivided loyalty toward the principal, and must act in accordance with the highest principles of morality, fidelity, loyalty and fair dealing. Consistent with this duty, an agent may not make a gift to himself or a third party of the money or property which is the subject of the agency relationship. Such a gift
carries with it a presumption of impropriety and self dealing

The Court also notes that many of the checking account records are missing, thus indicating a failure on the part of Karen H. to "keep a record of all receipts, disbursements, and transactions entered into by the agent . . .". General Obligations Law § 5-1505(2)(a)(3).

MEDICAL DECISIONS

Family Health Care Decisions Act
Article 29-CC of Public Health Law

- Allows a surrogate (from a list by priority) to make medical determinations including end of life decisions for someone who is found to be incapacitated by physicians.
- Court Appointed Guardian is first on the list

In the Matter of the Application of Northern Manhattan Nursing Home, Petitioner, for the Appointment of Person and Property of A.M.; 32 Misc.3d 754, 928 N.Y.S.2d 810, April 26, 2011.; Supreme Court New York County

In matter brought by emergency order to show cause, pursuant to Family Health Care Decision Act (FHCDA), guardian of 92–year–old nursing home resident moved for order authorizing it, as guardian of person and property of incapacitated person, to act on his behalf in withholding consent to his intubation with Percutaneous Endoscopic Gastronomy (PEG) feeding tube, to diagnostic testing, and to medical treatment of metastasized cancer, and further authorizing it to act on his behalf in granting consent to palliative and/or hospice care, and in executing orders of Do Not Resuscitate (DNR) and Do Not Intubate (DNI).


Daughter filed petition, under Mental Hygiene Law (MHL), for appointment as guardian, primarily to make end-of-life decisions, for her 93-year-old mother suffering from advanced Alzheimers disease and residing in nursing home. Daughter and Catholic Family Services were appointed co-guardians, principles of ward’s Roman Catholic religious beliefs were determined to apply to end-of-life decisions, pursuant to Family Health Care Decisions Act (FHCDA), and prior medical orders on life-sustaining treatments (MOLSTS) and directives, with exception of do not resuscitate (DNR), were permanently revoked, as unauthorized and violating ward's religious belief and prior request to be artificially administered nourishment.