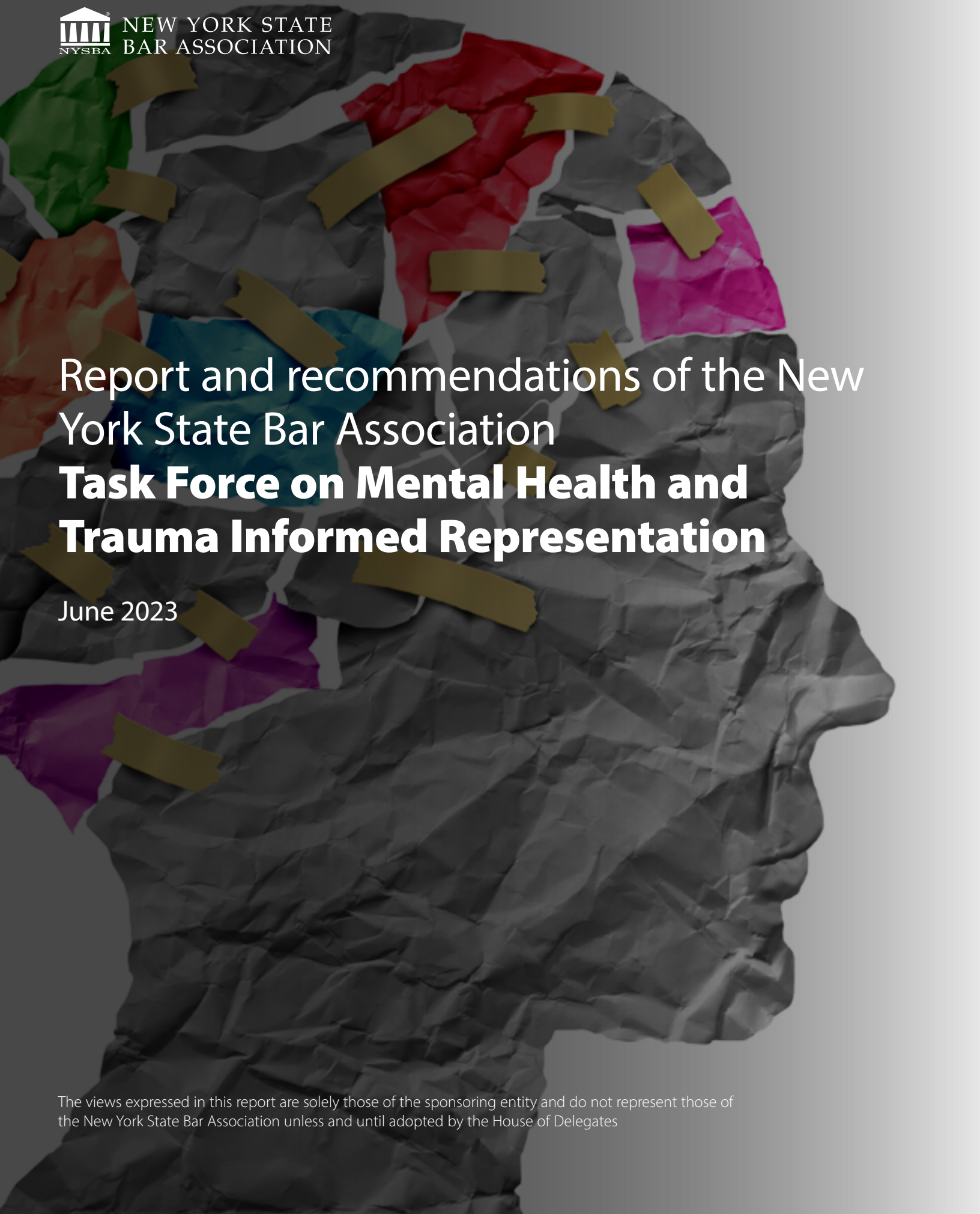
NEW YORK STATE BAR ASSOCIATION



Report and recommendations of the New York State Bar Association **Task Force on Mental Health and Trauma Informed Representation**

June 2023

Report and Recommendations of the **Task Force on Mental Health and Trauma Informed Representation**

April 2023

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Preface to the Report – A Note on Language

In rendering this report the members of the Task Force begin with a comment on language. As Nicholas Kristoff reminds us, language can be inclusive or alienating and it can also be divisive. [1] Many organizations have guides to writing style. For example, the American Medical Association ("AMA") released a 54- page guide on language to advance health equity.[2] The AMA states its goal is not to provide a list of "correct terms" but to provide guidance on equity-focused, person-first language and to among other things, avoid stigma.[3] Language promotes stigma when an illness is placed before the person, giving primacy of the illness (e.g., mental illness) over the human being.[4] Throughout this Report we have endeavored to use "person-first" language.[5]

As Dr. Thomas Insel, former director of the National Institute of Mental Health ("NIMH") reminds us, "the labels we use are simply conventions with limitations. Labels like 'illness' or 'disorder' describe a set of symptoms. They do not define a person." [6] Mr. Kristoff cautions that inclusive language must be a call to action and not a substitute for it. [7] Toward this end, and with a call for action,

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1 https://www.nytimes.com/2023/02/01/opinion/inclusive-language-vocabulary.html?smid=nytcore-ios-share&referringSource+articleShare

2 See, American Medical Association, *Advancing Health Equity: A Guide to Language, Narrative and Concepts (*2021).

3 *Id*. at p. 7, 45.

4 *Id*. at p. 45-46

5 This choice recognizes that some people with disabilities might prefer "identity first" language. While person first language is used in the title of the 1990 landmark civil rights law, the Americans with Disabilities Act, many in the disability community now prefer identity language which expresses disability pride with direct statements – such as I am deaf or I am autistic. A recommendation emerges from the University of Kansas Research and Training Center on Independent Living to ask the person you are writing or speaking about which approach they prefer. In a report such as this, person first language is recognized as respectful. *See*, https://rtcil.org

6 Thomas Insel, M.D., *Our Path from Mental Illness to Mental Health* (2022)

7 *Supra*, note 1.

Task Force member Chris Liberati-Conant persuasively argues in his January/February 2023 New York State Bar Association *Journal* article that "It's time to take 'hygiene' out of the Mental Hygiene Law"[8] Mr. Liberati-Conant observes, "there are many difficult issues related to mental health. This is not one of them." As his article explains, the term "mental hygiene" in our State Constitution and related statutes is associated with the eugenics movement. The Task Force agrees that it is time to remove "hygiene" from the Mental Hygiene Law. Adopting a modern nomenclature that does not stigmatize people with mental disabilities is certainly more reflective of the values of our community. This change is long overdue. A final note on language, because our Task Force investigation is not exclusive to people with mental illness, in this -report we use the statutory term "mental disability" in context because that term is defined more broadly to encompass "mental illness, intellectual disability, developmental disability, or an addictive disorder."[9]

Executive Summary

According to the NIMH nearly one in five adults in the United States live with a mental illness-over 50 million people in 2020-and over 13 million adults live with serious mental illness.[10] In his book, "*Healing: Our Path from Mental Illness to Mental Health*,"[11] Thomas Insel chronicles the failures in virtually every

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[8] Chris Liberati-Conant, *It's Time to Take 'Hygiene' Out of the Mental Hygiene Law*, 95 -Feb N. Y. St. B. J. 21 (2023).

[9] MHL § 1.03 (3).

[10] https://www.nimh.nih.gov/health/statistics/mental-illness

According to the NIMH website, the data is from the 2020 National Survey on Drug Use and Health ("NSDUH") by the Substance Abuse and Mental Health Services Administration ("SAMHSA"). For inclusion in NSDUH prevalence estimates, mental illnesses include those that are diagnosable currently or within the past year; of sufficient duration to meet diagnostic criteria specified within the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-IV"); and exclude developmental and substance use disorders. Any mental illness ("AMI") is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment (e.g., individuals with serious mental illness as defined below). Serious mental illness ("SMI") is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI.

[11] Insel, *supra,* note 6.

aspect of our mental health system, including the ineffective delivery of care, the gutting of community health services and the reliance on police and jails for crisis services. Insel describes an "epiphany" during his last year at NIMH, after he had delivered a presentation to a group of advocates, touting researchers' progress on identifying genetic markers for various mental illnesses. A man in a flannel shirt appeared increasingly agitated during the presentation. When the question-and-answer period began, he rose to his feet to ask the Dr. Insel a question: "You really don't get it. My twenty-three-year-old son has schizophrenia. He has been hospitalized five times, made three suicide attempts, and now his is homeless. Our house is on fire," the man said, "and you are talking about the chemistry of the paint. What are you doing to put out this fire?" Dr. Insel writes that in that moment, "I knew he was right. Nothing my colleagues and I were doing addressed the ever-increasing urgency or magnitude of the suffering millions of Americans were living through — and dying from."[12]

In March 2020, the Conference of Chief Justices ("CCJ") and Conference of State Court Administrators ("COSCA") established the National Judicial Task Force to Examine State Courts' Response to Mental Illness to "assist state courts in their efforts to more effectively respond to the needs of court involved individuals with severe mental illness." Former New York Chief Administrative Judge Lawrence K. Marks was a Task Force Co-Chair.

The October 2022 report of the Task Force, *State Courts Leading Change*, observed:

> "Court leaders cannot solve the 'chaos and heartbreak of mental health in America.' Court leaders can, and must, however, address the impact of the broken mental health system on the nation's courts-especially in partnership with behavioral health systems. The broken system too often negatively impacts court cases involving those with mental illness, especially in competency proceedings, criminal and juvenile cases, civil commitment cases, guardianship proceedings for adults and juveniles, and family law cases. Each state court, as well

[12] *Id*., p. xvi-xvii. Thomas Insel, the 'Nation's Psychiatrist,' Takes Stock, With Frustration - The New York Times (nytimes.com)

as CCJ and COSCA, are urged to initiate a thorough examination of the mental health crisis and its impact on fair justice."[13]

Creation of Task Force on Mental Health and Trauma Informed Representation

Recognizing that the mental health crisis confronts our nation, state, localities and court system in profound ways, NYBA President Sherry Levin Wallach conceived and convened a NYSBA "Task Force on Mental Health and Trauma Informed Representation" as one of her first official acts. The mission statement of the Task Force was ambitious and provided:

> "The Task Force on Mental Health and Trauma Informed Representation is created to explore, study, and evaluate the intersection between the mental health crisis and our civil and criminal justice systems. There is a well-documented crisis of mental health care in the United States that has failed to meet the needs of people with mental health challenges and/or histories of trauma. People living with mental health challenges or trauma histories are increasingly incarcerated, homeless, or boarded in hospital emergency rooms. They often bear additional burdens and stigma of racial discrimination, sex or gender identity discrimination, and poverty. The task force will focus on the need for the bar to better serve individuals with mental health challenges and/or trauma histories, both adults and children, through trauma-informed practice, such as informing attorneys and the judiciary of available resources to assist in the representation of clients, by raising awareness of intersectional stigma and trauma and by recommending education on best practices in the representation of these clients. Criminal diversion and civil processes will be examined to ensure that people living with mental health challenges and/or trauma histories are able to fully participate in legal proceedings that impact their liberty and well-being. State policy and budget priorities will be examined and appropriate recommendations made."

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[13] *See, State Courts Leading Change*, Report and Recommendations (October 2022); From the 2016-2017 Policy Paper Adopted by CCJ/COSCA, "Decriminalization of Mental Illness: Fixing a Broken System." Leading Change | NCSC

The Task Force membership included lawyers engaged in the private practice, advocates for people with disabilities, criminal law attorneys, attorneys who advise local and state governmental entities delivering mental health services, attorneys with disabilities and attorneys with joint degrees who are practicing psychologists. The Task Force had a psychiatric advisor. With the Committee on Attorney Well-Being, the Task Force co-sponsored the January 18, 2023, NYSBA Presidential Summit where the theme was *Mental Health and the Justice System: Impacts, Challenges, Potential Solutions*. A remarkable conversation with Zack McDermott and his mother, Cindy McGilvrey, authors of the *Gorilla and the Bird: A Memoir of Madness and a Mother's Love,* was facilitated by Task Force Member Libby Coreno, at the Annual Meeting. That interview provided the audience with a remarkable account and lived experiences of a person who is a practicing lawyer with mental illness.[14]

When reporting to the House of Delegates on January 20, 2023, Task Force co-chair Joseph Glazer personalized the charge of the Task Force when he said: "I become informed by reading … I become responsive by taking action. We have a responsibility to meet our clients where they are." The theme of the January/February issue of the New York State Bar Association *Journal* was *Trauma, Mental Health and the Lawyer*. The lead article was written by Task Force member Libby Coreno. Task Force co-chairs Joseph Glazer and Sheila Shea and members Patricia Warth, and Chris Liberati-Conant were also contributors to the *Journal*.[15] The full Task Force report explores the historical antecedents to the current mental health crisis. It identifies the areas of inquiry that the Task Force undertook and seeks to meet the challenge of President Sherry Levin Wallach who stated in her President's Message leading the January/February *Journal*:

> "There is considerable work to be done to ensure equity and fairness in the justice systems for people with mental illness, trauma and disabilities. We need to have a system of care that is set up to the challenging task of serving clients with complex needs. Our organization must lead and join with others to ensure diversity and equity across all programs designed to improve outcomes for people with mental disabilities who are involved in the criminal justice

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[14] *See*, Paula L. Green and Jennifer Andrus, *The Criminalization of Mental Illness: Incarceration's Effect on Mental Health and Trauma*, State Bar News, Annual Meeting 2023, Vol. 65, No. 1, p. 4.

[15] Task Force member Jamie A. Rosen with Douglas Stern, was subsequently published in the March/April 2023 NYSBA Journal, writing on *The Unique Role of the Guardian in Inpatient Psychiatric Care*.95 -Apr N. Y. St. B. J. 43 (2023).

system. We must act now. Our task force, comprising more than two dozen leaders across New York State, will publish a report in the coming year. A choir of voices and perspectives is needed in every effort to improve court and community responses to individuals with mental disabilities. We need to be among the more prominent voices in that chorus urging reform." [16]

Investigation

The full membership of the Task Force convened regularly commencing in August of 2022, and later broke into separate sub-committees that studied issues pertaining to criminal justice, civil justice, seamless systems and trauma informed practice. It met periodically with experts and advocates to inform its judgments. The Task Force invited the Honorable Matthew D'Emic, Brooklyn Mental Health Court, to be its first guest presenter. Trista Borra, J.D., M.S.W., New York State Unified Court System, Office for Justice Initiatives, Statewide Director, Child Welfare Court Improvement Project ("CWCIP"), Aimee L. Neri, M.S.W., CWCIP 8th Judicial District Coordinator, Bridget O'Connell, J.D., M.S.W., Alternative Dispute Resolution ("ADR") Coordinator, 5th. 6th, 7th and 8th Judicial Districts and Court of Claims, and Sadie Ishee, J.D., Deputy Chief Attorney, Mental Hygiene Legal Service, First Judicial Department followed to address the Task Force on trauma and informed practices. Stephanie Marquesano, J.D., founder and president of "the harris project, " provided tremendous insights to the Task Force toward promoting co-occurring disorders awareness, prevention and advocacy. Harvey Rosenthal, Executive Director and Luke Sikinyi, Policy Director, New York Association of Psychiatric Rehabilitation Services ("NYAPRS") offered the Task Force with perspectives from the advocacy community. Cheryl Roberts, Esq., Executive Director, Greenburger Center for Social and Criminal Justice, spoke to the Task Force from multiple perspectives, including as a part-time City Judge implementing justice initiatives in her Columbia County community.[17] Dr. David Moore addressed the Task Force remotely from Australia where he successfully advocated to bring restorative justice principles into practice. The Commissioner of the Office of

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[16] Sherry Levin Wallach, *Lawyers Must Address Impact of Mental Health on Criminal Justice,*. 95 - Feb N. Y. St. B. J. 6,7 (2023).

[17] Judge Roberts described the Sequential Intercept Model ("SIM") and explained how Hudson, New York created a SIM map for its community. *See Report to Begin Decriminalizing Substance Use Disorders and Serious Mental Illness* Decriminalizing Substance Use Disorders and Serious Mental Illness (cityofhudson.org)

Mental Health ("OMH"), Dr. Ann Marie T. Sullivan addressed the Task Force as did the Commissioner of the Office for People With Developmental Disabilities ("OPWDD"), Kerri Neifeld, through her designee, Dr. Jill Pettinger. Task Force Member Sophie I. Feal, also attended and reported back to the Task Force on the progress of the Attorney General Letitia James' public hearings on the mental health crisis in New York State.[18]" Task Force Members Jeffrey Berman and Sabina Kahn testified at the Attorney General's New York City hearing.

While the Task Force investigation was ongoing, New York Governor Kathy Hochul released her 2023-2024 Executive Budget proposal on February 2, 2023. The Executive Budget identified many priorities of interest to the Task Force, including:

- $700 million to bolster mental health inpatient, outpatient and residential programs statewide, bringing total investment in mental hygiene sector to $10.5 billion for the upcoming fiscal year.

- $890 million in capital investment to build 3,150 new residential beds for people with mental illness who need varying levels of support.

- Adding 1,000 inpatient beds in the OMH system which is part of a multi-year plan to increase capacity at mental health facilities. Included in this total are 850 acute care beds in psychiatric wards of general hospitals that were "repurposed" during the COVID crisis as medical-surgical beds and 150 new beds in State operated psychiatric hospitals.

- Adding 39 beds at a cost of $11.7 million dollars in the OPWDD system at the former Finger Lakes Developmental Center campus as an intensive treatment option for people with developmental disabilities.

- 2.5 % cost-of-living increases to community based not-for-profit human services providers. [19]

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[18] Mental Health Hearing | New York State Attorney General (ny.gov)

[19] Briefing Book | FY 2023 Executive Budget (ny.gov) As reported in the Albany Times Union. https://www.timesunion.com/state/article/detailed-breakdown-gov-kathy-hochul-s-executive-17757303.php *See,* Joseph Glazer, Testimony to the Joint Legislative Budget Hearing

On February 16, 2023, the New York State Legislature convened a Joint Legislative Public Hearing on the 2023 Executive Budget Proposal. The Task Force considered the public hearing testimony when rendering its -report.[20]

The Task Force closed its investigation on March 31, 2023, and emerged with recommendations addressed to the Executive, Legislative and Judicial branches of government. An overview of the recommendations follows. The balance of the Task Force report provides context for its recommendations with an appendix of sources considered during its deliberations. The Task Force mission was broad, and the condensed time within which to conduct our inquiry led to a consensus that NYSBA should exercise continuing leadership in this space and consider creating a standing mental health committee that continues this valuable work. This recommendation is not new. On November 18, 2018, the NYSBA Committee on Mandated Representation issued a report and recommendation to establish a task force or standing committee on mental health. [21] Part of that goal was realized with the creation of the Task Force on Mental Health and Trauma Informed Representation. The Task Force has completed its work, but there is a need for education and advocacy to continue because the scope of the issues pertaining to mental health and trauma that confront our society are enormous. In our opinion, there is no more persuasive justification for the establishment of a standing mental health committee than the words of Professor Michael Perlin who observed:

> "Mental Disability is no longer-if it ever was-an obscure subspeciality of legal practice study. Each of its multiple strands forces us to make hard social policy choices about troubling social issues-psychiatry and social control, the use of institutions, informed consent, personal autonomy, the relationship between public perception and social reality, the many levels of 'competency,' the role of free will in the

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Proposed 2023-204 NYS Budget Hearing on Mental Hygiene (Feb. 16, 2023). Appendix Document 1, outlining budget priorities of the Executive.

[20] Joint Legislative Public Hearing on 2023 Executive Budget Proposal: Topic Mental Hygiene | NY State Senate (nysenate.gov)

[21] *See, Report to the Executive Committee of the New York State Bar Association on the Use and Efficacy of Penal Law 40.15 and Criminal Procedure Law 330.20 and Recommendation to Establish a Mental Health Task Force or Committee* (Robert Dean, Chair) (2018). Appendix Document 2

> criminal law system, the limits of confidentiality, the protection duty of mental health professionals, the role of power in forensic evaluations. These are all difficult and complex questions that are not susceptible to easy, formulistic answers." [22]

As the quote from Professor Perlin reminds us, the work of the Task Force only touches upon some of the many issues that are worthy of continued study by the Association.

Overview of Recommendations

Court System

- In his 2023 *State of Our Judiciary* address, Judge Anthony Cannataro, Acting Chief Judge of the State of New York, announced that the court system will create a committee to implement the recommendations from the National Judicial Task Force to Examine State Courts' Response to Mental Illness (*State Courts Leading Change*). The Task Force supports this initiative and recommends that the newly formed committee include representatives from within the court system, including, judges, court personnel, court officers, Americans with Disabilities ("ADA") compliance officers, and the directors of Attorneys For Children ("AFC") and Mental Hygiene Legal Service ("MHLS") programs and outside of the Office of Court Administration ("OCA"), such as prosecutors, public defense providers, legal service organizations and New York's federally funded protection and advocacy organization, Disability Rights New York ("DRNY")
- The court system should also study innovations emerging from other states, including Texas and its Judicial Commission on Mental Health ("TJCMH"). The TJCMH has developed literature and tool kits toward connecting people to treatment rather than jails while preserving community safety by diverting non-violent adults and youth with behavioral health issues to less restrictive, more healing environments to promote reform [23]

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[22] Michael L. Perlin, *Half-Wracked Prejudice Leaped Forth: Sanism, Pretexuality, and Why and How Mental Disability Law Developed as It Did*, 10 J. Contemp. Legal Issues 3, 31 (1999).

[23] Texas JCMH | Texas Judicial Commission on Mental Health

- The Task Force joins in the recommendations of the "Report from the Special Adviser on Equal Justice in the New York State Courts" (the "Johnson Report") that there be substantial implicit bias training of Judges, court personnel and juries as a high priority of the court system in New York.

- The court system should conduct training on implicit bias and disability.
- The Task Force agrees that a full-time mental health professional should be engaged by OCA to oversee the implementation of these training programs.

- Further, additional funding should be available, especially to smaller communities, for the creation of specialty courts in those areas and for the training of both judicial and non-judicial personnel in the proper operation of those courts.

- The court system should collect relevant data regarding the demographics of those involved in the criminal justice system and the outcomes of their cases so that further study can help to continue to improve the goal of equality of justice especially for those who are mentally disabled or a member of a traditionally targeted racial or gender population.

- The court system should also develop a methodology to encourage the submission of the ideas and suggestions of individual judges, lawyers, correction officials, and staff as well as those who are directly impacted by the current inequities in the system to improve the system.

- OCA should add information and forms to its website guiding users in the process to remove a guardian and to the newly enacted Supported Decision Making statute ("SDM") as a guardianship alternative. [24]

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[24] *See,* Mental Hygiene Law ("MHL") Article 82. Surrogate's Court Article 17-A guardianship forms can be found at: https://ww2.nycourts.gov/forms/surrogates/guardianship.shtml

- OCA should update its guidelines for attorneys accepting guardian ad litem appointments.[25]

Legislature

- Pass the *Treatment Not Jail Act*, or consistent legislation to provide courts with guided discretion needed to authorize diversion, as opposed to incarceration, for people entangled in our criminal justice system who need services and support for mental disabilities.
- Restore legislative appropriations for the New York State Law Revision Commission ("LRC") to promote criminal and civil law reform.[26]
- Hold public hearings on particularly vexing problems within the service delivery system such as the boarding of people with multiple disabilities in emergency rooms and hospitals.
- Hold public hearings to study comprehensive and collaborative community responses to people in crisis in formed by studies and models of responses in various jurisdictions.
- Hold public hearings to study the repeal of Social Services Law § 384-b(4)(c) and consideration of a parent's status as a person with mental illness or intellectual disability in other family court proceedings.
- Hold public hearings on the need for guardianship reform in New York State.
- Introduce legislation to specifically recognize Psychiatric Advance Directives ("PADs") in New York State.

Trauma Informed Practice

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[25] Publications Home Page | NYCOURTS.GOV - Guidelines for Guardian Ad Litem, with Sample Reports and Forms.

[26] Legislative Law § 70 is the enabling statute of the New York State Law Revision Commission ("LRC"). The LRC is the oldest continuous agency in the common-law world devoted to law reform through legislation. *See,* New York State Law Revision Commission | Revitalizing the law through reform and legislation Unfortunately, the LRC has not received legislative appropriations for over a decade completely frustrating its laudatory purpose.

- The court system and state and local bar associations should be encouraged to develop and implement attorney-focused practicum on mental disabilities and trauma to ensure a consistent and level understanding among practitioners and jurists.
- In conjunction with the New York State Judicial Institute, OCA should sponsor additional and training programs on trauma and trauma informed practices for judges and court attorneys.[27]
- OCA should also continue to encourage and support trauma informed training for attorneys within the court system working with vulnerable populations including the AFC and MHLS programs.
- The resources of existing model programs within the court system such as the Child Welfare Court Improvement Project ("CWCIP"), with its focus on trauma informed representation, should be promoted and enhanced.
- OCA should also study and implement principles of "restorative justice" in New York State as restorative justice is trauma informed.
- Law Schools should encourage trauma informed approaches in clinical legal education.

Systems Reform

- State and local authorities administering programs for people with mental disabilities should promote "seamless systems" change which would have three components: 1) people with needs being able to connect to the system of care at any point; 2) each point in the various systems of care recognizing their needs and being able to connect them to the proper service providers and supports; and 3) emphasis on maintaining recovery, with person-centered treatment planning as well as attention to social supports and determinants of health.

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[27] Established by Judiciary Law 219-a, the New York State Judicial Institute is a statewide, year-round center for judicial education, training and research. Another goal of the Judicial Institute is to provide a framework for facilitating an improved dialogue between the Judiciary, the practicing bar and the public. Judicial Institute - N.Y. State Courts (nycourts.gov)

- Promote a seamless system that includes and addresses co-occurring disorders, recognizing that individuals in need frequently have multiple or overlapping needs and disabilities.
- Seek alternatives to coercive interventions and promote non-hospital community voluntary crisis stabilization programs.
- Support "peer bridging" as a link between the hospital and a successful discharge plan.
- Promote community investment in supported housing units.
- Recommend that the Office of Mental Health ("OMH"), the Office for People With Developmental Disabilities ("OPWDD"), and the Office of Addiction Services and Supports ("OASAS") and the Department of Health to collaborate and adopt integrated service regulations without further delay.
- Recommend that OMH and OPWDD operate or fund respite beds for children and adults with disabilities to avoid boarding in hospital emergency rooms.

Criminal Justice

- Support courts and communities in the use the Sequential Intercept Model to map resources, opportunities and gaps, and develop plans to improve court and community responses to individuals with mental illness, addiction, developmental disabilities, and co-occurring conditions.
- Advocate for funding and resources needed to implement a continuum of diversion programs, treatment and related services to improve public safety as a more humane and cost-effective approach when individuals with mental illness, addiction, developmental disabilities, and co-occurring conditions interface with the criminal legal system.
- Adequately fund beds in both the OMH and OPWDD systems for inpatient restoration for people in the criminal justice system determined to be incapacitated, while requiring OMH and OPWDD to expand and promote the clinical infrastructure required to permit outpatient restoration whenever possible.

- Recommend that those people admitted to the hospital or a developmental center for restoration must receive full and co-occurring competent care.
- Recommend an amendment to Article 730 of the Criminal Procedure Law ("CPL") to remove statutory requirement that the District Attorney consent to outpatient restoration, while providing prosecutor with notice and an opportunity to be heard before an outpatient restoration order is issued.
- Promote the development and utilization of community-based alternatives to CPL Article 730, including respite and crisis respite, crisis services and community-based restoration.
- OCA should promulgate official forms to implement CPL Article 730.
- Study and re-examine CPL 330.20 to ensure that it meets its dual objectives of promoting public safety while meeting the treatment needs of people subject to its provisions.
- OCA should update official forms that implement CPL 330 to reflect those commitments can be to either the custody of OMH or OPWDD.
- Foster and support efforts to ensure that diversion and problem-solving courts are linked to service systems that competently, effectively and efficiently serve participants, allowing for better outcomes and the fullest possible application of justice.
- Consistent with the recommendation made in the *State Courts Leading Change* report, explore, foster and support efforts to deflect and divert people with mental disabilities from the criminal legal system prior to or immediately after arrest.
- Commit to full implementation of Humane Alternatives to Long-Term ("HALT") Solitary Confinement Act and resist efforts to rollback these reforms that are critical to the human and effective treatment of people with mental disabilities who are incarcerated.

<u>Civil Justice</u>

- Promote autonomy of individuals with mental disabilities through supported decision-making principles.

- Introduce legislation to require recognition of PADs even without proxies in all settings, to fund peer and provider trainings to facilitate their use, and to establish means of transmission, such as registries and web-based access.
- Amend MHL Article 81 to explicitly include supporters for decision-making as "available resources" as defined under MHL § 81.03(e), when considering the need for and/or scope of guardianship.
- OMH should convene a working group to review supported decision-making processes in New York State, to promote peer supports and social environments that are conducive to supported decision-making and to explore the possibility of a pilot project relating SDM and psychiatric advance directives.
- OMH and OPWDD should collaborate to further the use of SDM for individuals with dual diagnoses, including any necessary reasonable accommodations, and to address the needs of people who are dually diagnosed when developing the upcoming OPWDD regulations implementing MHL Article 82.
- Promote reform of guardianship statutes in New York State and provide procedural pathways for individuals subject to guardianship to seek modification of existing orders and restoration of rights.
- Promote Single Transaction Orders as a less restrictive intervention than a plenary guardianship.
- Support amendment of the Extreme Risk Protection Order statute, CPLR Article 63-a, to add a right to counsel for respondents.
- Support amendment of the New York State Constitution and related statutes to remove references to "mental hygiene" and adopting a modern nomenclature that does not stigmatize people with mental health conditions and is more reflective of the values of the community.

<u>Accommodations</u>

The Task Force recommends that the court system adopt the following recommendations with respect to disability accommodations:

- Ensure centralized decision-making to reduce inconsistency throughout the court system.
- Establish an administrative review process for all judicial accommodation denials.

- Documentation for judicial accommodation requests should be the same as required for administrative accommodations.
- Place guidelines for reviewing accommodation requests into the Judge's Desk Book.

The Task Force also endorses a recommendation made by the New York Lawyers Assistance Group ("NYLAG") in a report it published in 2021 which is that "whenever litigants with disabilities struggle with either in-person or virtual proceedings, the court must consider whether a switch to the other format would serve as an appropriate accommodation."[28]

NYSBA

- Establish a standing Mental Health Committee to address pronounced systemic issues that may not fit within an existing single Section or Committee's purview. Elder Law and Special Needs Section, Health Law Section, Committees on Civil Rights, Mandated Representation and Disability Rights should have at least one member serve as a liaison to the standing Mental Health Committee.

I. Historical Antecedents to Current Crisis

Author Andrew Scull writes that if we are to confront the challenges that mental disabilities present to all of us, we shall have to take account of social and political realities.[29] "The decisions to confine the mentally ill to the madhouse and, more recently, to decant them to unwelcoming 'communities' have drastically affected what it means to be mentally ill."[30]

Almost sixty years ago, in 1963, the federal Community Mental Health Act ("CMA") was adopted with great hope and promise.[31] President John F. Kennedy

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[28] NYLAG Issue Brief, *Access to Justice in Virtual Court Proceedings: Lessons Learned from COVID 19 and Recommendations for New York State Courts*. https://nylag.org>wp-content>uploads>2021>NYLAG_CourtsDuringCovid_WP_FINAL.pdf at p. 18

[29] Andrew Schull, *Desperate Remedies: Psychiatry's Turbulent Quest to Cure Mental Illness* (2022), 384.

[30] *Id.*

[31] Public Law 88-164; https://www.govtrack.us/congress/bills/88/s1576
The legislation is also known as the Community Mental Health Centers Construction Act ("CMHCCA"). The Act established federal funds to help defray the costs of constructing (but not staffing) local clinics. Federal support for staffing, which was administered by the federal

remarked upon passage of the Act "that the mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities." The CMA accelerated the process of deinstitutionalization,[32] but what was supposed to be a comprehensive, community-based health care system collapsed under the weight of the Vietnam War, the Watergate scandal and shifting federal priorities.[33] During the Reagan administration, remaining funds for the Act were converted to mental health block grants for the States.[34] From 1981 onward, "the federal government's reluctant disengagement from mental health policy quickly gave way to determined retreat." [35] As noted by Dr. Insel, federal policy failed people with serious mental illness contributing to homelessness, incarceration and early mortality for this population.[36] Task Force member Patricia Warth echoes this observation and further explains in her compelling article *Unjust Punishment:*

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department of Health Education and Welfare ("HEW"), was passed in 1965. CMHCCA was a radical break from previous national mental health policy in both the kind of facilities it supported and the degree of direct federal involvement that it represented but did not clearly define the target populations of the community centers or their relationship to other local health-care institutions. *See,* Bonita Weddle, *New York State Archives, Mental Health in New York State 1945-1998, An Historical Overview* (Publication Number 70), text citing to note 54 (publication is not paginated). Appendix Document 3

[32] In terms of closing state hospitals and reducing the number of people confined to mental health institutions, the deinstitutionalization movement was an overwhelming success. "Between 1950 and 2000 the number of people with serious mental illness living in psychiatric institutions dropped from almost half a million people to about fifty thousand," while the number of beds in state and county psychiatric hospitals declined by more than 90%. *See*, Patricia Warth, *Unjust Punishment: The Impact of Incarceration on Mental Health*, 95 Feb-N. Y. St. B. J. 11 -12 (2023), *citing* Alisa Roth, *Insane: America's Criminal Treatment of Mental Illness* 81,92 (2018).

[33] Insel, *supra,* note 6 at p. 28-34. *See,* Weddle, *supra* note 31, text citing to note 69 - The escalating conflict in Vietnam "increasingly occupied attention of President Johnson" and "drained money from social welfare programs." The pace of center development fell far short of projections. As of early 1967, 26 centers were receiving funding for construction and staffing, when 2,000 centers were projected to open nationwide.

[34] *See* Smith, Michelle R. (20 October 2013). *50 years later, Kennedy's vision for mental health not realized*. *The Seattle Times*.

[35] *See,* Weddle, *supra* note 31, text citing to notes 172, 173. The federal government's abdication of responsibility occurred at the same time the states and local governments were confronted with monumental social and economic problems, and as a result was "particularly disastrous for the mentally ill." *Id*., *citing* Gerald N. Grob, *The Mad Among Us* (1994) pp. 286-287.

[36] Insel, *supra,* note 6 at p. 35. *See,* American Psychiatric Association, *The Psychiatric Bed Crisis in the U.S. Understanding the Problems and Moving Toward Solutions* (2022), *explaining* the historic and contemporary uses of psychiatric beds. https://www.psychiatry.org/news-room/news-releases/apa-report-psychiatric-bed-crisis

The Impact of Incarceration on Mental Health, [37] that in the last quarter of the 20th century, the dramatic reduction of inpatient mental health care was accompanied by an equally dramatic increase in criminalization and incarceration.[38] Often referred to as "transinsitutionalization," this increase in incarceration was historically unprecedented.[39]

In 1993, New York State adopted its own Community Mental Health Reinvestment Act[40] designed to ensure that funds from steadily closing state psychiatric hospital beds followed people living with mental illness back to the

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[37] Warth, *supra*, note 32.

[38] In 1973, the United States incarcerated adults at a rate of 161 per 100,000 adults; by 2007, this rate had quintupled to 767 per 100,000. In absolute terms, "the growth in the size of the penal population has been extraordinary; in 2012, the total of 2.23 million people held in U.S. prisons and jails was nearly seven times the number in 1972." *See,* Warth, *supra* note 34, National Research Council 2014, The Growth of Incarceration in the United States: Exploring Causes and Consequences, Washington, DC: The National Academies Press, https://doi.org/10.17226/18613, at 33, 35-36.

[39] Sol Wachler & Keri Bagala, *From the Asylum to Solitary: Transinstituionalization*, 77 Alb. L. Rev. 915 (2014). Patients were also moved from state hospitals to other institutional settings such as nursing homes. Fiscal policy choices incentivized discharges as the New York State Archives report explained. *See,* Weddle, *supra* note 31, text citing to note 67. Medicare and Medicaid were created in 1965 and among other things sharply limited Medicaid reimbursement for the cost of care furnished in state hospitals causing "unanticipated and dramatic consequences." The Hon. Cheryl Roberts, who addressed the Task Force, explains the origins of the federal Institutions of Mental Disease or "IMD Rule," and its consequences for people with severe mental illness. Judge Roberts argues that federal funding should be restored for certain facilities with bed limitations that would extend the continuum of care, while guarding against abuses of the past. https://greenburgercenter.org/congress-must-stop-blocking-mental-health-clinics-from-needed-money-cheryl-roberts-nydn-op-ed/

[40] L. 1993, c. 723 § 9 included community mental health reinvestment services in a five-year plan and annual implementation plans and budgets. *See* MHL § 41.55; Swidler RN, Tauriello JV, *New York State Community Mental Health Reinvestment Act*. Psychiatr Serv. 1995 May: 46(5); 496-500. Appendix Document 4 The goals of the 1993 Reinvestment Act were frustrated. Using "notwithstanding" language in many annual state budgets, funds intended to be allocated for local community-based programs were redirected to general government expenses. Contrary to the legislative intent, billions of dollars have not followed people from the inpatient psychiatric hospitals back to their communities and homes.

See https://www.nyaprs.org/e-news-bulletins/2013/nys-legislators-issue-proposal-to-restore-community-mh-reinvestment-program
https://assembly.state.ny.us/comm/Mental/20021031/report.html (*Broken Promises, Broken Dreams: A Report on the Status of the Mental Health Delivery System in New York State*) (2002)

community, but the goals of the legislation were not achieved. For example, large numbers of people with mental illness were placed into other types of institutions, including nursing homes and adult homes. This was the result of a "conscious State policy" to discharge patients from psychiatric hospitals into these facilities "due to the absence of other housing alternatives at a time when psychiatric centers were under pressure to downsize." [41] Even now, despite more investment in mental health services, OMH maintains that 3.1 million New Yorker's live in federal and/or state designated "mental health shortage areas."[42] Innumerable commentators and our own observations as lawyers lead us to conclude that the system of care is broken with unsustainable trends, and partially explained in large part by the lack of resources available to support people with significant mental health needs who are often living in poverty.[43]

II. Task Force Areas of Inquiry

A. *Overview - Policy and Practice*

Court System

Promoting systemic change in a broad context means contributions from all branches of government are required. Indeed, in the *State Courts Leading Change* report, it is recommended that a state-level inter-branch mental health task force be established in each state and that the Administrative Office of the court system in each state consider the appointment of a behavioral health director and team to improve court responses for court-involved individuals with serious mental illness.[44] The court system has tremendous incentive to contribute to solving the mental health crisis through specialty courts and other means. The *2023 State of Our Judiciary* address includes a section on "Mental Health in Our Courts." [45] The

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41 *See Disability Advocates, Inc. v Paterson*, 598 F. Supp. 2d 289, 297 (E.D.N.Y. 2009).

42 https://omh.ny.gov/omhweb/planning/strategic-framework/index.html

43 "Although most spending on social services, mental health, and public health flows through - and is reflected in - county budgets, the bulk of the money in those categories comes from state aid, not money the county itself raises or controls. From 2011 to 2019, New York State**:** cut aid to counties for behavioral health and social services by 8 percent — from $12.3 billion to $11.3 billion; and reduced state spending (that does not flow through county budgets) on human services by 21 percent from 2011 to 2017 and by 26 percent from 2017 to 2018." s*ee The Cost of Incarceration in New York State* (2021) https://www.vera.org/publications/the-cost-of-incarceration-in-new-york-state

44 *See, State Courts Leading Change*, *supra* note 13 at 47.

45 www.nycourts.gov/whatsnew/pdf/23_SOJ-Speech.pdf

court system announced it will form a committee to implement the recommendations from the National Judicial Task Force to Examine State Courts' Response to Mental Illness (*State Courts Leading Change*).[46] Guided by the National Task Force's report, OCA states it will focus on strengthening its community partnerships and reviewing its existing procedures and protocols to ensure that, in every way possible, the courts are taking an empathetic, humane, and effective approach to mental and behavioral health. The Honorable Matthew D'Emic, who is a pioneer in mental health courts, will chair the OCA committee. Further, the State of the Judiciary address indicates that the blue-ribbon committee will bring together experts, governmental partners, and community leaders to put the recommendations of the National Task Force into practice. [47]

The Task Force endorses the creation of the committee described in the *2023 State of Our Judiciary* address. We further recommend that the newly formed committee include representatives from within the court system, including, judges, court personnel, court officers, Americans with Disabilities ("ADA") compliance officers, and the directors of Attorneys For Children ("AFC") and Mental Hygiene Legal Service ("MHLS") programs and outside of OCA, such as prosecutors, public defense providers, legal service organizations and New York's federally funded protection and advocacy organization, Disability Rights New York ("DRNY") The Task Force further observes that the Texas Judicial Commission on Mental Health ("TJCMH") is a potential model for an OCA-sponsored Task Force within the New York judiciary. The TJCMH devotes itself toward connecting people to treatment rather than jail while preserving community safety by diverting non-violent adults and youth with behavioral health issues to less restrictive, more healing environments. [48]

The OCA plan to invest further resources to mental health courts is desperately needed. The Task Force is mindful, though, that contrary to general

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[46] *Id.* The *2023 State of Our Judiciary* speech observes: "Our problem-solving courts - overseen by Judge Toko Serita -include 42 Mental Health Courts across the state, and we have more mental health initiatives in development. The Ninth Judicial District, administered by Judge Anne E. Minihan, recently launched a misdemeanor wellness mental health court in Westchester County to complement its existing felony mental health court. And, in the Fourth Judicial District, supervised by Administrative Judge Felix J. Catena, Essex County recently opened a Superior Part for Mental Health Treatment."

[47] www.nycourts.gov/whatsnew/pdf/23_SOJ-Speech.pdf

[48] *See*, Stacey Soule, *Transforming the Judiciary*, 85 Tex. B. J. 842 (2022).

assumptions, mental illness is not considered a risk factor for criminal conduct.[49] Mental health courts work, but as Carol Fisler, a New York City-based consultant and formerly with the Office of Court Innovation argues, more research is needed to identify the current aspects of court design and operations that should be emphasized while at the same time introducing new program elements based upon research findings.[50]

Finally, any discussion of problems in the justice system would be remiss if it did not highlight rampant racial inequity and injustice. A recent study commissioned by former Chief Judge DiFiore and conducted by former Homeland Security Secretary Jeh Johnson entitled "Report from the Special Adviser on Equal Justice in the New York State Courts" (the "Johnson Report") remarked that:

> "The sad picture that emerges is in effect, a second-class system of justice for people of color in New York State. This is not new. In 1991, a Minorities Commission appointed by then Chief Judge Wachtler declared 'there are two justice systems at work in the courts of New York State, one for Whites and a very different one for minorities and the poor.'"

The Johnson Report also highlighted what it referred to as "the vile, racist Facebook posting by a Brooklyn-based court officer" which it said "appears to have peeled the lid off long-simmering racial tensions and intolerance within the court officer community" noting that that situation had also been mentioned in the 1991 Minorities Commission report.

For Black, Indigenous, People of Color (BIPOC), or those in the LGBTQIA+ community who live with a mental health condition, racism and prejudice can exacerbate their challenges. The stigma of mental illness is intersectional: a person's race, ethnicity gender, social class, age or housing status in addition to their mental health diagnosis, generates differing stigma experiences. For example, even if two people have the same diagnosis (e.g., bipolar disorder) a young and homeless BIPOC living in poverty is exposed to more extensive stigmatization than a young White non-Latinx middle-class person

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[49] Carol Fisler, *When Research Challenges Policy and Practice*, Spring 2015 Judges Journal, Vol. 54, No. 2 (2015). *See*, Paula L. Green, *Mental Health Courts Operate with Compassion*, State Bar News, Annual Meeting, Volume 65 No.1 (2023), p. 27, quoting Carol Fisler at 2023 NYSBA Annual Meeting: "[P]overty usually drives the criminal behavior of a defendant ending up in mental health courts, rather than their mental illness."

[50] *Id.* at p. 11.

who is stably housed. Moreover, due to the shameful legacy of racism and discrimination, Black and Brown communities are more impacted by poverty and less likely to receive adequate treatment for underlying mental health issues. Mental health diagnoses such as major depression go undiagnosed and untreated at disproportionally greater rates in majority Black and Latinx communities.[51] The same systemic failures that propagate generational poverty and mental illness also make it more likely for impacted people to be unable to access therapeutic services.[52]

The emerging literature on the family and community effects of mass incarceration points to negative health impacts on the female partners and children of incarcerated men and raises concerns that excessive incarceration could harm entire communities and thus might partly underlie health disparities both in the USA and between the USA and other developed countries. The Johnson Report also mentions that "countless interviewees told us that mandatory implicit bias and cultural sensitivity training is long overdue for judicial and non-judicial personnel in the New York State court system. At present, it appears that such training is both inconsistent and insufficient."

The Task Force joins in the recommendations of the "Report from the Special Adviser on Equal Justice in the New York State Courts" (the "Johnson Report") that there be substantial implicit bias training of Judges, court personnel and juries as a high priority of the court system in New York. Training is also needed to ensure that courts take an empathetic, humane, and effective approach to mental and behavioral health. The Task Force agrees that a full-time mental health professional should be engaged by OCA to oversee the implementation of these training programs. Additional funding should be available, especially to smaller communities, for the creation of specialty courts in those areas and for the training of both judicial and non-judicial personnel in the proper operation of those courts.

The court should collect relevant data regarding the demographics of those involved in the criminal justice system and the outcomes of their cases so that further study can help to continue to improve the goal of equality of justice especially for those who are mentally disabled or a member of a traditionally

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[51] Racial Disparities In Diagnosis and Treatment of Major Depression, Blue Cross Blue Shield, May 31, 2022, Racial Disparities in Diagnosis and Treatment of Major Depression (bcbs.com

[52]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5192088/#:~:text=Barriers%20to%20Accessing%20and%20Using20Mental%20Health%20Services&text=It%20is%20estimated%20that%20among,and%20even%20fewer%20co mplete%20treatment

targeted racial or gender population. While this information should be made public, such transparency should be accomplished in a manner sensitive to the immigration status or other collateral consequences impacting disenfranchised people. The court system should also develop a methodology to encourage the submission of the ideas and suggestions of individual judges, lawyers, correction officials, and staff as well as those who are directly impacted by the current inequities in the system to improve the system.

Executive

In the narratives that follow, the Task Force will explain that the "O" agencies comprising the Department of Mental Hygiene in New York will likely spend near $10.5 billion dollars in fiscal year 2024 to meet the needs of more than 1,000,000 people with mental disabilities in New York State. [53] This sizeable investment includes a 17% budget increase for OMH which Commissioner Sullivan characterized as "historic" during her testimony before the Joint Legislative Committee on February 16, 2023. While the investment is desperately needed, it must also be smart to achieve its objectives.

Legislature

a. *Hold public hearings on emergent critical issues in the service delivery system.*

The Legislature should consider holding public hearings to address tragic gaps in the system of care that result, for example, in teens and young adults boarding in hospital emergency rooms when community supports could not be marshaled to prevent a crisis or establish a safe discharge plan. In one reported case, a teenager with intellectual disabilities spent over 36 days in the emergency room at the Champlain Valley Physicians Hospital in Plattsburgh, New York.[54] Regrettably, these and similar cases repeat themselves in substantial numbers and at great harm as well documented by both the American College of Emergency Room Physicians and thirty-four other signatories on a November 22, 2022 letter to the Biden Administration (on a national level) and the Healthcare Association of New York State ("HANYS").[55] HASNY observes that hospitals across the country and in New

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53 Briefing Book | FY 2023 Executive Budget (ny.gov)

54 *See*, *MHLS v Delaney*, 176 A.D. 3d 24 (3d Dept. 2019), *appl dismissed*, 38 N.Y.3d 1076 (2022)

55 https://www.hanys.org/communications/publications/scope_of_complex_case/

The psychiatric advisor to the Task Force, Dr. Laura Gardner, also shared a letter sent by the American College of Emergency Physicians and 34 other signatories to the Biden

York have reported an alarming rise in patients who become caught in limbo in emergency departments and inpatient units for weeks, months, and even years after they are medically ready for discharge. These delays most often occur due to a lack of care options, the inability to pay for post-discharge care and/or administrative gridlock. Complex case discharge delays, also known as bed blocking or boarding, are devastating for patient, exacerbate bed shortages and result in enormous unnecessary costs. Some of the longest delays are experienced by children with mental health needs and people with developmental disabilities.[56]

Another urgent area for study by the Legislature is the response to mental health crisis calls in the community. This is an issue of federal, state and local concern. On the federal level, on May 25, 2022, the Biden Administration issued Executive Order ("E.O.")14074 entitled *Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety*. Section 14 of E.O. 14074 provides:

> "*Promoting Comprehensive and Collaborative Responses to Persons in Behavioral or Mental Health Crisis.* (a) Within 180 days of the date of this order, the Attorney General and the Secretary of HHS, in coordination with the heads of other agencies and after consultation with stakeholders, including service providers, nonprofit organizations, and law enforcement organizations, as appropriate, shall assess and issue guidance to State, Tribal, local, and territorial officials on best practices for responding to calls and interacting with persons in behavioral or mental health crisis or persons who have disabilities.
>
> (b) The assessment made under subsection (a) of this section shall draw on existing evidence and include consideration of co-responder models that pair law enforcement with health or social work professionals; alternative responder models, such as mobile crisis response teams for appropriate situations; community-based crisis centers and the facilitation of post-crisis support services, including supported housing, assertive community treatment, and peer support

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Administration explaining the national scope and tremendous personal and economic costs associated with maintaining people in emergency rooms and hospitals without medical need. Appendix Document 5

[56] The Seamless Systems section of this report will further explain the crisis and describe a potential response in Massachusetts that New York may wish to study.

services; the risks associated with administering sedatives and pharmacological agents such as ketamine outside of a hospital setting to subdue individuals in behavioral or mental health crisis (including an assessment of whether the decision to administer such agents should be made only by individuals licensed to prescribe them); and the Federal resources, including Medicaid, that can be used to implement the identified best practices."[57]

On February 7, 2023, a coalition of advocates[58] wrote to the Department of Justice to emphasize their commitment to alternative unarmed responders for crisis calls involving vulnerable populations - including people with mental health conditions, deaf people, autistic people, and people with intellectual and developmental disabilities. The letter noted that these populations are at heightened risk for harm from police encounters, which can often turn deadly, especially when the person involved is Black.[59] The advocates further observed that the risk of harm to the vulnerable individual is so great, and the actual threat to public safety usually small, that law enforcement response to a mental health crisis be avoided whenever possible. The advocates letter to the President highlighted local communities, including Albany County, New York, that have piloted programs where unarmed teams answer 911 calls that would otherwise receive a police response by default.[60]

During our investigation, the Task Force considered various studies and bills that could lead to crisis response and systems reform in New York State. We endorse the following (12) fundamental guiding principles for developing or modifying response systems that currently place people with mental illness in danger. The principles emerge from the John Jay College of Criminal Justice, Disability Rights New York report *Systems in Crisis Identifying Critical Issues in Response to Mental Health Crisis Calls*:[61]

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[57] Federal Register :: Advancing Effective, Accountable Policing and Criminal Justice Practices To Enhance Public Trust and Public Safety

[58] The coalition was comprised of The Leadership Conference, Legal Defense Fund, Bazelon Center for Mental Health Law, National Urban League, Human Rights Watch, NAACP, the Arc of the United States, and the Vera Institute of Justice. Appendix Document 6

[59] *Citing*, Legal Defense Fund & Bazelon Center for Mental Health Law, *Advancing An Alternative to Police: Community-Based Services for Black People with Mental Illnes*s (2022) Appendix Document 7

[60] https://www.albanycounty.com › home › showpublisheddocument › 22105 (Albany County Crisis Officials Responding and Diverting [ACCORD])

[61] Report available at: https://www.drny.org/page/investigation--monitoring-reports-40.html

1. Replacement of Police Officers as First Responders

Review the legal, ethical and cultural factors that support replacement of police officers as first responders in the majority of circumstances where a call for assistance for a person in acute mental health crisis has been made.

2. Engage Community Stakeholders

Engage diverse stakeholders to discuss a non-police response model. Communities are urged to take the time required to accomplish such engagement and digest the information gained during the engagement process. Stakeholders must be kept apprised of all critical benchmarks in the development process. Communities should not succumb to demands for identification of a model and plan for implementation by federal or state entities which provide an inadequate timeline in which to make critical decisions. Stakeholders must avoid the "us vs. them" distinctions between the community at large and people with mental illness. It should be recognized by all stakeholders that people with mental illness are members of the community that members of the community may have current or past mental illness, and that police officers also develop mental illness. By breaking down these barriers and acknowledging that mental health crisis can occur to anyone, stakeholders can consider what kind of crisis response they would want for themselves or their loved ones.

3. Utilize Data

Utilize a data-driven approach to develop alternative response models. Consider patterns of response outcomes in individual neighborhoods and particularized impact on BIPOC individuals. Where relevant data is not immediately available, every effort should be made to access such data before critical determinations are made regarding the models being considered.

4. Create the Model That is Right for Your Community

Evaluate the unique cultural dynamics of the community to develop a model for respond to community members needing mental health assistance. This includes attaining stakeholder input about community goals and priorities, examining other successful models, and exploring new creative solutions and the means to attain them.

5. Work for Consensus on Community Safety

Seek consensus, based on feedback from diverse stakeholders, about what factors will be used to determine when dispatchers shift from initiating a presumptive non-police response to initiating a high-acuity response that includes police officers. Community discussion must consider the harms that result from addressing mental health crisis from a criminal perspective.

6. Carefully Consider Mechanism of Dispatch

Careful consideration should be given to how a caller places a request for assistance. Where the traditional 9-1-1 system is being considered, stakeholders must acknowledge that the police department, using traditional dispatch protocols within its purview, may maintain a high level of control over response determinations. Where an alternative number and/or platform for communication is being considered, a protocol for collaborative evaluation of some calls for assistance will be required. Where stakeholders are considering an alternative number/platform, they must consider the need for a robust public education campaign to inform the public when and how the new system is to be accessed. Stakeholders must consider developing the right professional profile for dispatch personnel, and the need for robust and continuing training which integrates dispatch personnel into training provided to response team members.

7. Identify the Right Professionals for First Response

First response should include a multidisciplinary team of professionals who are uniquely suited to the important task of safely assisting people in acute mental health crisis. Team members may include mental health professionals, emergency services professionals and peer specialists whose skills compliment and support those of other team members. Communities should not rule out creation of team positions for individuals who combine elements of these disciplines and others, providing for development of a specialized vocation ideally suited to the agreed-upon standards of community stakeholders, including people with mental illness.

8. Incorporate Robust and Sustained Training

Training must be comprehensive and reinforced to regularly incorporate information derived from stakeholder experiences. Training should be culturally competent and explicitly trauma informed, including the implications of vicarious trauma. Training should place the work in a historical context, encouraging understanding of how police culture and the

experiences of BIPOC community members' impact on behaviors exhibited during response. Wherever practicable, team members should be trained together to enhance the value of multidisciplinary exchange and support team cohesion. Training should adhere to the principles of "recovery-oriented" services that de-emphasizes coercion and emphasizes participant choice whenever possible, so that crisis workers are not used as de-facto police officers.

9. Revise Training for Police Officers Responding to High-Acuity Calls

Where police officers in new response models will respond only in designated high-acuity situations and in the context of a team response model, police officer training should be revised to reflect the role of the police officers in relation to other team members. Police officer training should also be immediately adapted to incorporate information (as set forth above) regarding the intersections of mental health and race, the unique impacts of such events on BIPOC communities, the impacts of such events on children with mental illness, and the need to view all people in crisis as representative of multiple identities. Police training must be regularly updated and, to every degree practicable, integrated into the training of other team members and dispatchers with whom they will partner.

10. Adopt A Presumption Against Non-Confinement

Communities should develop a model that embraces a presumption against non-confinement, including emergency admission into acute care facilities, where other available options are appropriate. Inherent in this presumption is a community commitment to develop and cultivate mental health services and supportive housing options. Response team training should consistently emphasize this presumption.

11. Incorporate Localized Mental Health Services

Stakeholders should examine existing neighborhood mental health services and cultivate and support expansion of creative new services by highly localized providers that support objectives of the chosen model. Where commitment of resources to a new response model is matched with commitment to highly localized non-acute mental health services, the

potential for acute mental health crises, and the potential for tragedy, will be reduced.

12. Commit to Transparency and Adaptation

Communities should commit to full transparency in reports back to the community on model successes and failures. This commitment must include addressing any deficiencies in modification of original policies and procedures, with priority given to those which directly impact on the safety of people in mental crisis and response team members.[62]

b. Restore funding for Law Revision Commission.

The Legislature should restore appropriations for the New York State Law Revision Commission ("LRC"). Defunded since 2016, the LRC is the oldest continuous agency in the common-law world devoted to law reform through legislation. [63] Among many other initiatives, the LRC was the drafter of the Insanity Defense Reform Act of 1980[64] and Article 81 of the MHL,[65] the general guardianship statute in our state. The Task Force makes several recommendations for further study and possible legislative reform and the LRC should be a partner in these endeavors.

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[62] The Albany Law School Government Law Center released an informative report in 2020 entitled *Alternatives to Police as First Responders: Crisis Response Programs*. Crisis Response programs in Eugene, Oregon, Austin, Texas, Olympia, Washington, and Edmonton, Alberta, Canada are examined and explained. https://www.albanylaw.edu/government-law-center/alternatives-police-first-responders-crisis-response-programs

[63] New York State Law Revision Commission | Revitalizing the law through reform and legislation

[64] Insanity Defense Reform Act of 1980. L.1980, c. 548. That Act, in turn, was recommended by the New York Law Revision Commission in a Report prepared in response to a specific request of Governor Carey. Session Laws of New York, 1981, pp. 2251–2293; *see also* Memorandum on Approving L.1980, c. 548, Session Laws of New York, 1980, p. 1879–1880 and Report of the Law Revision Commission of the State of New York, 1980 at Session Laws of New York, 1980, pp. 1599.

[65] L. 1992, c. 698. A three-year study by the LRC led to the enactment of MHL Article 81. The statute repealed and replaced New York's conservator and committee statutes (former Articles 77 and 78 of the MHL).

c. *Hold public hearings to study the repeal of Social Services Law § 384-b(4)(c) and consideration of a parent's status as a person with mental illness or intellectual disability in other family court proceedings.*

In the mid-1970s, New York enacted its contemporary law governing the termination of parental rights, Social Services Law § 384-b. Under § 384-b(4)(c), a court may terminate a parent's rights if they "are presently and for the foreseeable future unable, by reason of mental illness or intellectual disability, to provide proper and adequate care for a child who has been in the care of an authorized agency for the period of one year immediately prior to the date on which the petition is filed in the court …."[66] In the years 2006 - 2008, between 346 and 296 petitions to terminate parental rights were brought in New York on the ground of mental illness or intellectual disability.[67]

In 2009, a coalition of organizations advocated for the elimination of this ground for termination of parental rights. As noted in a statement in support of S.2835/A.6668,[68] when the law was drafted in 1975, "it would have been difficult to predict the changes that have taken place over the last thirty-five years for individuals with psychiatric disabilities. The thought process in 1975 was that these are static conditions that could not be changed. As we know now, nothing could be further from the truth."[69] The coalition stated that, "[t]o use mental illness as grounds for permanent termination is an archaic vestige of an outmoded and discredited view of mental disabilities still reflected by a law written almost forty years ago. It is a discriminatory practice that treats people with psychiatric disabilities and developmental disabilities as second-class citizens without the

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[66] Social Services Law § 384-b(6)(a) defines the term "mental illness" and 384-b(6)(b) defines the term "intellectual disability."

[67] Mental Health Association of New York State, Termination of Parental Rights Bill Update (June 5, 2009). https://web.archive.org/web/20090804193118/http://www.mhanys.org/publications/mhupdate/updatelatest.htm

[68] https://assembly.state.ny.us/leg/?default_fld=&leg_video=&bn=A06668&term=2009&Summary=Y&Actions=Y&Memo=Y&Text=Y

[69] Mental Health Association of New York State, Termination of Parental Rights Bill Update (June 5, 2009). https://web.archive.org/web/20090804193118/http://www.mhanys.org/publications/mhupdate/updatelatest.htm

same rights as individuals without these disabilities." A similar bill has been proposed as recently as 2018.

Several articles have addressed the discriminatory nature of New York's law.[70] In addition to the problems with focusing on the status of the parent as a person with a mental illness or intellectual disability,[71] "New York courts have consistently decided not to read the reasonable efforts requirement into the part of the statute governing cases of mental illness." (citing *Matter of Jammie "CC,"* 149 A.D.2d 822 (3d Dept 1989).

In 2017, the American Bar Association's House of Delegates adopted Resolution 114 urging all governments:

> "to enact legislation and implement public policy providing that custody, visitation, and access shall not be denied or restricted, nor shall a child be removed or parental rights be terminated, based on a parent's disability, absent a showing—supported by clear and convincing evidence—that the disability is causally related to a harm or an imminent risk of harm to the child that cannot be alleviated with appropriate services, supports, and other reasonable modifications."

The New York State Legislature should hold public hearings to study whether § 384-b(4)(c) should be repealed. This study should also address whether other statutes or caselaw permit the family court to consider a parent's status as a person

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[70] *See* Brandon R. White, *Termination of Parental Rights of Mentally Disabled Parents in New York: Suggestions for Fixing an Overbroad, Outdated Statute*, 34 Buff Pub Int LJ 1 (2015); Jeanne M. Kaiser, *Victimized Twice: The Reasonable Efforts Requirement in Child Protection Cases When Parents Have a Mental Illness*, 11 Whittier J Child & Fam Advoc 3 (2011); Dale Margolin, *No Chance to Prove Themselves: The Rights of Mentally Disabled Parents Under the Americans with Disabilities Act and State Law*, 15 VA J Soc Pol'y & L 112 (2007); Susan Kerr, *The Application of the Americans with Disabilities Act to the Termination of the Parental Rights of Individuals with Mental Disabilities*, 16 J Contemp Health L & Pol'y 387 (2000). *See also* Should a Mental Illness Mean You Lose Your Kid?, Pro Publica (May 30, 2014), https://www.propublica.org/article/should-a-mental-illness-mean-you-lose-your-kid.

[71] At least one author has concluded that "New York's law is also discriminatory in that it allows a court to terminate parental rights on the basis of status; without services, parents with mental disabilities cannot demonstrate their individual capabilities, and judges therefore cannot make decisions based on the mental illness instead of the parent's individual capabilities." Margolin, 15 VA J Soc Pol'y & L at 170. *See also* Leslie Francis, *Maintaining the Legal Status of People with Intellectual Disabilities as Parents: The ADA and the CRPD*, 57 Fam Court Rev 21 (2019) (noting that a New York court found that the ADA does not apply to termination of parental rights proceedings).

with mental illness or intellectual disability in a way that does not reflect current understanding of such disabilities and the resources available to support parents.[72]

Recommendations

- The Task Force endorses creation of a committee within the court system to implement the recommendations from the National Judicial Task Force to Examine State Courts' Response to Mental Illness. The Task Force recommends that the newly formed committee include representatives from within the court system, including, judges, court personnel, court officers, Americans with Disabilities ("ADA") compliance officers, and the directors of Attorneys For Children ("AFC") and Mental Hygiene Legal Service ("MHLS") programs and outside of OCA, such as prosecutors, public defense providers, legal service organizations and New York's federally funded protection and advocacy organization, Disability Rights New York ("DRNY")
- The court system should study innovations emerging from other states, including Texas and its Judicial Commission on Mental Health ("TJCMH"). The TJCMH has developed literature and tool kits toward connecting people to treatment rather than jails while preserving community safety by diverting non-violent adults and youth with behavioral health issues to less restrictive, more healing environments to promote reform.
- The Task Force joins in the recommendations of Secretary Johnson that substantial quality training of Judges, court personnel and juries on implicit bias should be a high priority of the court system in New York.
- The court system should conduct training on implicit bias and disability.
- The Task Force agrees that a full-time mental health professional should be engaged by OCA to oversee the implementation of these training programs.
- Further, additional funding should be available, especially to smaller communities, for the creation of specialty courts in those areas and for the

[72] *See, e.g.,* Kaplan & Brusilovskiy, *Custody Challenges Experienced by Parents with Serious Mental Illnesses Outside of Child Protective Services Proceedings*, Psychiatric Rehab J 44(2), 197 (2021) (finding that "[m]ore than one third of parents with an SMI experienced custody challenges other than those brought by CPS.").

training of both judicial and non-judicial personnel in the proper operation of those courts.

- The court system should collect relevant data regarding the demographics of those involved in the criminal justice system and the outcomes of their cases so that further study can help to continue to improve the goal of equality of justice especially for those who are mentally disabled or a member of a traditionally targeted racial or gender population.

- The court system should also develop a methodology to encourage the submission of the ideas and suggestions of individual judges, lawyers, correction officials, and staff as well as those who are directly impacted by the current inequities in the system to improve the system.

- The Legislature should hold public hearings on particularly vexing problems within the service delivery system such as the boarding of people with multiple disabilities in emergency rooms and hospitals**.**

- The Legislature should public hearings to study comprehensive and collaborative community responses to people in crisis in formed by studies and models of responses in various jurisdictions.

- The Legislature should hold public hearings to study the repeal of Social Services Law § 384-b(4)(c) and consideration of a parent's status as a person with mental illness or intellectual disability in other family court proceedings.

- The Legislature should restore appropriations for the LRC to promote criminal and civil law reform.

B. *Trauma Informed Practices*

"On its most basic level, trauma occurs when an event happens to an individual, or group, over which they have no control, with little power to change their circumstances, and which overwhelms their ability to cope..."[73]

[73] Libby Coreno, *Trauma, Mental Health the Lawyer*, 95-Feb. N. Y. St. B.J. 8 (2023).

The Task Force endeavored to define trauma as a foundational exercise upon which to build recommendations. The American Psychological Association defines trauma as "[A]n emotional response to a terrible event like an accident, rape, or natural disaster." [74] Task Force member Dr. Robert Goldman, J.D., Psy.D., defines trauma as "a deeply distressing or disturbing event that has long-lasting effects on an individual's mental, emotional, and physical well-being. A single event, such as a car accident or a natural disaster, or prolonged exposure to traumatic circumstances, such as abuse, crime, or combat can cause it. Trauma can manifest in various ways, including anxiety, depression, post-traumatic stress disorder (PTSD), and, most notably, crime." [75]

Comprehensive research has found that multiple childhood traumatic events have lifelong impact on those subjected to them. Often referred to as "ACEs" (adverse childhood experiences), a study conducted in the mid-1990s by the Centers for Disease Control and the Kaiser Foundation determined the long-term impact of childhood trauma. Specifically, the collaborative study of hundreds of thousands of Kaiser Permanente patients, led by pediatrician Dr. Nadine Burke Harris and conducted between 1995 and 1997, was the first to examine the relationship between early childhood adversity and negative lifelong health effects. The research found that the long-term impact of ACEs determined future health risks, chronic disease, and premature death. Individuals who had experienced multiple ACEs also faced higher risks of depression, addiction, obesity, attempted suicide, mental health disorders, and other health concerns. It also revealed that ACEs were surprisingly common – almost two-thirds of respondents, part of the white, well-off sample, reported at least one ACE. While the study demonstrated a high prevalence of trauma sustained by children, adults can frequently be traumatized as well. And the impact of trauma manifests for years to come, especially if undiagnosed and unresolved.[76]

As Task Force member Libby Coreno noted in her lead article in January/February 2023 NYSBA *Journal, Trauma, Mental Health and the Lawyer,* there is no question that anyone who traverses the legal system -particularly the

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[74] http://apa.org/search?query=trauma

[75] https://www.psychologytoday.com/intl/blog/building-resilient-minds/202301/the-use-of-restorative-justice-as-a-trauma-informed-approach

[76] *See,* Sheila E. Shea Joseph A. Glazer, *50 Years After Willowbrook: Mental Disabilities and the Law in New York State,* 95 Feb-N. Y. St. B. J. 17 (2023) and the authorities cited therein.

criminal justice system or our family courts-is at risk for exposure to trauma. She quotes Natalie Netzel, who states that:

> "On its most basic level, trauma occurs when an event happens to an individual, or group, over which they have no control, with little power to change their circumstances, and which overwhelms their ability to cope..."[77]

New research suggests that experiencing psychological trauma at a young age nearly triples a person's risk to suffer from mental illness in the future, with researchers thus concluding that trauma can be considered a "transdiagnostic construct"[78] Dr. Goldman observes that research has shown that there is a strong link between trauma and criminal behavior.[79] Further, Dr. Goldman argues that the current criminal justice system can be retraumatizing to individuals who have experienced trauma in a number of ways. Some examples include:

1. Re-victimization: The process of reporting a crime, going through a trial, and facing the offender can be re-traumatizing for the victim, especially if they are not provided with appropriate support and resources.

2. Lack of sensitivity: Many criminal justice professionals may not be trained to recognize the signs and symptoms of trauma and may not understand the impact their words or actions can have on a trauma survivor.

3. Re-traumatization during incarceration: Prisons and jails can be high-stress environments that can trigger memories and feelings of past traumatic experiences for individuals who have been incarcerated.

4. Inadequate mental health care: Individuals with trauma-related mental health conditions may not receive appropriate care

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[77] Libby Coreno, *Trauma, Mental Health the Lawyer*, 95-Feb. N. Y. St. B.J. 8 (2023).

[78] *See, Massive review study suggests psychological trauma nearly triples a person's risk of mental disorder,* PsyPost, 1/10/23

[79] https://www.psychologytoday.com/intl/blog/building-resilient-minds/202301/the-use-of-restorative-justice-as-a-trauma-informed-approach; *citing,* Ardino V. Post-traumatic stress in antisocial youth: A multifaceted reality. In: Ardino V, editor. Post-traumatic syndromes in children and adolescents. Chichester, UK: Wiley/Blackwell Publishers; 2011. pp. 211–229.

while in the criminal justice system, leading to an increased likelihood of reoffending and perpetuation of their trauma.

5. Stigma: Trauma survivors may be stigmatized by criminal justice professionals, which can further compound the feelings of shame, guilt, and isolation they may already be experiencing.

Dr. Goldman credits the many criminal justice professionals and organizations who are working to address these issues and implement trauma-informed practices to minimize the re-traumatization of individuals in the criminal justice system. The Task Force also heard from people engaged intimately in trauma informed practices at OCA. Our members were greatly influenced by the presentations of Trista Borra, J.D., Statewide Director, Child Welfare Court Improvement Project ("CWCIP"), Aimee L. Neri, M.S.W., the CWCIP 8th Judicial District Coordinator, Bridget O'Connell, J.D., M.S.W., an Alternative Dispute Resolution Coordinator, and Sadie Ishee, J.D., Deputy Chief Attorney, Mental Hygiene Legal Service, First Judicial Department, who have brought trauma informed principles from theory to practice.[80]

Court system employees can also experience vicarious trauma. The October 22, 2022, *Leading Change* report observes that sixty-three percent of judges have at least one symptom of secondary or vicarious trauma and fifty percent of court child protection staff experience high or very high levels of compassion fatigue.[81] Recognizing the enormous implications of trauma for litigants, attorneys, and court personnel, the Task Force recommends training judges, court personnel and attorneys in relation to trauma.

In this regard, trauma-informed care for judges refers to an approach to the administration of justice that recognizes the prevalence of trauma among those who intersect with the legal system.[82] It acknowledges the impact that trauma can

[80] Families involved in the family court system often experience trauma, particularly during the course of custody and visitation, abuse and neglect, permanency, and termination of parental rights proceedings. The ongoing work of the CWCIP to bring trauma informed principles to family courts is encouraging and should be expanded to local child protective services agencies and the New York State Office of Children and Family Services. There is substantial work that needs to be done within the child welfare and family court systems to avoid stigmatization of parents with mental illness or intellectual disabilities.

[81] *State Courts Leading Change*, *supra,* note 13, at p 41.

[82] *See*, Eva Mckinsey, Samantha Zottola, Alexis Mitchell, Mark Heinen, and Luke Ellamker, *Trauma-Informed Judicial Practice from the Judges' Perspective*, Bolch Judicial Institute,

have on their experiences and behaviors. In a trauma-informed judicial system, judges, and other court personnel are trained to understand the effects of trauma and how it can influence an individual's interactions with the legal system. This includes recognizing signs of trauma in litigants, witnesses, and other participants in the justice process and making steps to mitigate the re-traumatization that can occur because of judicial proceedings.

A trauma-informed judicial system also involves creating a safe and supportive environment in the courtroom. This can include providing clear and understandable information about the judicial process to litigants, avoiding practices that could be anticipated to retraumatize individuals, and making reasonable accommodations to support the participation of individuals who have experienced trauma. The goal of a trauma-informed approach to justice is to improve the experiences of litigants and others who participate in the judicial process to better ensure that justice is served and to promote healing and recovery for individuals who have experienced trauma.

The components of trauma-informed training for judges typically include the following:

1. *Understanding trauma*: Judges and court personnel are trained to understand the nature and effects of trauma, including the biological, psychological, and social impacts of traumatic experiences.
2. *Recognizing trauma:* Participants in the training learn how to recognize signs of trauma in individuals who interact with the court system, and to respond in a way that minimizes re-traumatization.
3. *Creating a safe environment.* Training focuses on creating a safe, supportive and respectful environment in the court, where individuals who have experienced trauma can participate effectively. [83]

Duke University (2022) https://judicature.duke.edu/articles/trauma-informed-judicial-practice-from-the-judges-perspective/#:~:text=All%20judges%20recognized%20prioritization%20of,that%20courtroom%20in%20the%20future.

[83] The research findings published by Duke University provide clear examples of trauma informed practice. One recommendation is to reimagine the courtroom. Judges described the

4. *Minimizing re-traumatization.* Judges and court personnel are trained to understand how court proceedings and practices can retraumatize individuals and to take steps to minimize this risk.
5. *Trauma-informed communication:* Training teaches participants to communicate in a trauma-informed manner, including avoiding language and practices that might retraumatize individuals, and using language that is clear, respectful and not stigmatizing.
6. *Understanding and addressing trauma in diverse populations:* Participants learn about the unique experiences and needs of individuals from diverse populations who have experienced trauma, and how to address their needs in a culturally responsive manner.
7. *Preparing judges:* Preparing judges to address traumatic triggers in various contexts.
8. *Self-care:* Training often includes components of self-care, to help judges and court personnel manage the emotion and psychological impact of working with individuals who have experienced trauma. [84]

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need to "soften" the courtroom environment, structurally and procedurally. Regarding structure, several judges expressed support for the use of round conference tables in the well of the courtroom to discuss disposition decisions. They described situations in which it would be beneficial to come off the bench, perhaps without a robe on, and join courtroom participants at their same level to discuss next steps and solutions together. As for procedural changes, several judges noted the need to re-think who is in the courtroom and when. As one judge questioned: "I don't know what effect it might have if we have a murder case and the next case behind it is a kid who got in a fight in school . . . and they're seeing the murder defendant walking out in chains. Does that affect them?" Taking intentional steps toward creating an environment that is calming, supportive, and not re-traumatizing is an essential component of a trauma-informed courtroom. https://judicature.duke.edu/articles/trauma-informed-judicial-practice-from-the-judges-perspective/#:~:text=All%20judges%20recognized%20prioritization%20of,that%20courtroom%20in%20the%20future

[84] *Id.*, in part drawn from the "4Rs" of the SAMSHA trauma informed care approach. R*ealizing* the prevalence of trauma and potential pathways for recovery; *recognizing* signs and symptoms of trauma in the people who come through the courtroom; *responding* by integrating knowledge of trauma into practice; and actively *resisting re-traumatization*. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

The specific components of training for trauma-informed care for judges may vary, but the goal is always to improve the experiences of individuals who encounter the court system and to promote healing and recovery for those who have experienced trauma. Toward this end, video-hearings and trauma informed practices in remote environments must be considered and ongoing study is warranted. [85]

Lawyers must also engage in a professional shift from self-care to mutual care as so persuasively described by Libby Coreno. Tremendous work was done by NYSBA's Task Force on Attorney Well-Being which noted in its October 2021 report: "While the well-being of lawyers may seem like an individual's lawyer's problem, the data has been sounding an alarm for the better part of three decades that the training, culture, and economics of law contribute exponentially to the suffering in our profession." NYSBA has newly formed a Committee on Attorney Well-Being and has begun to cultivate new training programs for NYSBA members that focus on issue awareness and professional skill development - targeting the existential struggles, traumas and isolation that lead to suffering in our profession. This essential work must continue.

Finally, the Task Force encourages law schools and clinical legal education programs to implement trauma informed practices. The hallmarks of trauma-informed practice are when the practitioner puts the realities of the client's trauma experiences at the forefront in engaging with the client and adjusts the practice approach informed by the individual client's trauma experience. Trauma-informed practice also encompasses the practitioner employing modes of self-care to counterbalance the effect the client's trauma experience may have on the practitioner. Teaching trauma-informed practice in law school clinics furthers the

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[85] During the COVID crisis, physical distancing measures required courts to quickly adapt operations, the National Center for State Courts ('NCSC') saw an opportunity to examine the experience of families and child welfare court professionals in virtual hearings. With support from Annie E. Casey Foundation Inc. and Casey Family Programs, NCSC began a study that aimed to describe how families and court professionals experienced online court proceedings through the lenses of procedural fairness, access, and judicial engagement. The report of the study is found here: https://judicature.duke.edu/articles/best-practices-for-trauma-informed-virtual-hearings/..

goals of clinical teaching and is a critical aspect of preparing law students for legal careers.

Clinical professors Sarah Katz and Deeya Haldar[86] argue that teaching trauma-informed practice in law school clinics furthers the goals of clinical teaching and is a critical aspect of preparing law students for legal careers. According to the authors, trauma-informed practice is relevant to many legal practice areas and while clinical professors endeavor to teach students how to connect with their clients, equally challenging and important is helping students cultivate insight into identifying and addressing trauma and its effects. It is particularly crucial that law students be educated the effects of vicarious trauma and help them develop tools to manage its effects as they move through their clinical work and ultimately into legal practice. [87] At least four benefits can be anticipated:

1. *Better understanding of clients*: Trauma can have a significant impact on individuals, and a trauma-informed approach can help law students better understand the experiences of their clients and the challenges they may face in legal proceedings.
2. *Improved client outcomes*: By teaching trauma-informed practices, it can be anticipated that law students will learn to work more effectively with clients to address their needs and achieve better outcomes in legal cases. This can help reduce the adverse effects of trauma and increase the likelihood of positive outcomes for clients.
3. *Increased empathy:* A trauma-informed approach can help law students Develop greater empathy for their clients and a deeper understanding of the complex issues clients may face. This can foster a more supportive and legal environment for clients.
4. *Improved professional conduct*: A trauma-informed approach can help prepare law students for the demands of practice and provide insights into avoiding re-traumatization of clients and maintaining confidentiality. [88]

Restorative Justice

One response to trauma that can promote personal accountability and healing is restorative justice. As explained by our Task Force member, Dr. Robert

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86 *See,* Sarah Katz & Deeya Haldar, *The Pedagogy of Trauma Informed Lawyering*, 22 Clinical L. Rev. 359 (2016).

87 *Id*. at p. 361.

88 *Id.*

Goldman, "restorative justice" is a philosophy and a set of practices that aims to repair the harm caused by criminal behavior and address the needs of both the victim and the offender. Instead of focusing solely on punishment, restorative justice emphasizes the importance of repairing harm, restoring relationships, and rebuilding communities. This can involve bringing the offender and victim together in a facilitated meeting, called a restorative conference, where they can discuss the impact of the crime and work towards a resolution that addresses the needs of all parties involved. Unlike the traditional criminal justice system, restorative justice is victim focused. The traditional justice system often overlooks the needs of victims of crime. Research suggests that victims who participate in restorative justice processes are generally more satisfied with the outcome than those who go through the traditional criminal justice system. Victims who participate in restorative justice have reported feeling more heard and validated and have experienced a greater sense of closure and healing. They also reported feeling more satisfied with the outcome of the process, believing that justice was served and that the offender took responsibility for their actions.[89]

Restorative justice models can be found in around the world. The model is described in the following narrative:

> "Restorative justice can use a trauma-informed approach by recognizing the impact of trauma on both the victim and the offender and addressing those effects in the process of restoring harm and repairing relationships. By focusing on the traumatic impact, preventive strategies can be formulated. A trauma-informed restorative justice process would involve understanding the prevalence of trauma, recognizing signs and symptoms, responding with empathy and support, and taking steps to avoid re-traumatization. For the victim, a trauma-informed restorative justice process would involve creating a safe and supportive environment for them to share their experiences, feelings, and needs. It would also involve providing appropriate support and resources for them to heal from the trauma. For the offender, a trauma-informed restorative justice process would involve understanding the role of trauma in their criminal behavior and addressing those underlying issues as part

[89] https://www.psychologytoday.com/intl/blog/building-resilient-minds/202301/the-use-of-restorative-justice-as-a-trauma-informed-approach

> of their rehabilitation. Additionally, a trauma-informed restorative justice process would involve training and educating all involved parties, including facilitators, about trauma and its effects to create a more empathetic and effective process."[90]

On March 2, 2023, the Task Force heard from Dr. David Moore a restorative justice expert from Australia. Dr. Moore explained that restorative justice may seem like a new idea, but it has ancient origins. In fact, the concept has origins with indigenous peoples around the world, including Native American and Canadian First Nations civilizations. In New Zealand, where all juvenile crimes except murder go through a restorative process and adult crimes are automatically referred for similar consideration, the genesis lies in Maori traditions.[91] During his March 2, 2023 presentation, Dr. Moore informed the Task Force that restorative justice programs in the criminal context typically function in one of three ways: as a form of diversion from the criminal process, allowing offenders—especially young or first-time offenders—to avoid charges and a conviction; as a form of alternative sentencing; or, in more serious cases, as a way to reduce a criminal sentence. To date, 45 states in the United States have passed laws permitting the use of restorative justice in at least some criminal cases.[92]

Task Force Member Katherine LeGeros Bajuk observed that New York County District Attorney Alvin Bragg, Jr. implemented a restorative justice initiative.[93] Task Force Member Susan Bryant referred to the restorative justice

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90 *Id.*

91 *See also*, Lydialyle Gibson, *Restoring Justice: Exploring an alternative to crime and punishment* (2021). Restoring justice | Harvard Magazine

92 *Id*.

93 D.A. Bragg Creates "Pathways to Public Safety" Division to Elevate the use of Alternatives to Incarceration Across D.A.'s Office – Manhattan District Attorney's Office (manhattanda.org) - On March 2, 2022, the New York County D.A. created the Office's first Pathways to Public Safety Division ("Pathways") to elevate the use of diversion and evidence-based programming, ensuring individuals involved in the criminal justice system receive necessary services to reduce recidivism and enhance public safety. According to the press release announcing the program, this major restructuring will strengthen the Office's work related to alternatives to incarceration, specialized court parts, pre-arraignment diversion, restorative justice practices, and reentry practices. Additionally, Pathways will provide each of the six existing Trial Division bureaus with a dedicated prosecutor to serve as a resource from arraignment to sentencing, proactively identifying individuals who would benefit from diversion and programming without jeopardizing community safety.

program at the New York State Defender's Association ("NYSDA") where she is the Executive Director. NYSDA's program seeks to end cycles of violence and abuse at a community level, decrease incarceration and promote healing using restorative justice and trauma-informed practices. The program has focused on the Albany area, fostering healing in communities in Albany, Schenectady, and Ulster counties. As explained by NYSDA, restorative practices provide healthy and just alternatives to incarceration, detention, and suspension for a range of cases.[94]

The Task Force recommends the study, implementation and expansion of "restorative justice" programs in New York State. The NYSDA program can provide a model for other organizations to follow.

Recommendations

- The court system and state and local bar associations should be encouraged to develop and implement attorney-focused practicum on mental disabilities and trauma to ensure a consistent and level understanding among practitioners and jurists.
- In conjunction with the New York State Judicial Institute, OCA should sponsor additional and training programs on trauma and trauma informed practices for judges and court attorneys.
- OCA should also continue to encourage and support trauma informed training for attorneys within the court system working with vulnerable populations including the AFC and MHLS programs.
- The resources of existing model programs within the court system such as the Child Welfare Court Improvement Project ("CWCIP"), with its focus on trauma informed representation, should be promoted and enhanced.
- OCA should also study and implement principles of "restorative justice" in New York State as restorative justice is trauma informed.
- Law Schools should encourage trauma informed approaches in clinical legal education.

[94] https://www.nysda.org/page/RestorativeJustice

C. *Seamless Systems*

> *"Mental health systems optimally include a care continuum to meet people's needs in the most accessible, least restrictive environment. In broad perspectives, this continuum includes a range of services such as crisis services, accessible outpatient services, rehabilitation and recovery support services and inpatient psychiatric care*."[95]

The seemingly basic formulation of an optimally operating system of care has proven to be incredibly difficult to achieve in New York and across the country. The Task Force attempted to examine the service delivery system in New York toward making recommendations that will promote the integration of services to meet people where they are and at their greatest time of need. To better serve clients with complex needs, it is crucial to have a system of care that is up to the task. That not only means a full array of services, but a coordinated system that meets the needs of people with multiple and co-occurring disorders.

The "system" of care in New York state is vast. This report provides a brief overview of the system to provide additional context for the reader. To begin, there are no fewer than twelve state and local agencies are responsible for delivering services to people with mental disabilities in our state, in addition to the various funding streams and services, primarily Medicaid, provided through the federal and state governments.[96] On the State level, the Department of Mental

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[95] *See, supra*, note 36, American Psychiatric Association, *The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions (*2022), p. 3. https://www.psychiatry.org/psychiatrists/research/psychiatric-bed-crisis-report

[96] Briefing Book | FY 2023 Executive Budget (ny.gov) This total includes the near 49-million-dollar budget of the Justice Center for the Protection of People with Special Needs which performs a myriad of oversight functions to prevent the abuse and mistreatment of people with mental disabilities. *See generally*, https://www.justicecenter.ny.gov/.

Hygiene is divided into three autonomous agencies – OMH, OPWDD and OASAS – and each agency will be briefly described in turn, below.[97]

Office of Mental Health (OMH)

The public mental health system in New York is vast and the prevalence of mental illness in the population is high.[98] It is estimated that 832,509 people were served in the public mental health system in 2019.[99] This statistic reflects a steady rise from 2013, for example, when 729,000 were served.[100] Comparatively, the New York State population has remained relatively stable. OMH attributes the increase in its population served to several factors, including expanded eligibility criteria, behavioral health parity initiatives, high demand, increased awareness of mental health issues and stigma-reduction efforts.[101] The United States Substance Abuse and Mental Health Services Administration ("SAMHSA") defines any mental illness ("AMI") "as having at least one mental disorder, other than a developmental or substance-use disorder, in the past 12 months, regardless of the level of impairment."[102] Applying this metric, the prevalence rate of AMI for the New York State general population within the past 12 months for adults aged 18 and over in 2019 was 19.5%. [103]

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[97] The Executive Budget for proposes $10.5 billion dollars of combined spending in fiscal year 2024.[97] The Task Force heard from invited experts that the "O" agency silos have hindered the rendition of appropriate services and supports for people with dual or co-occurring diagnoses.

[98] https://my.visme.co/view/6x6nk6p6-profile-of-the-new-york-state-public-mental-health-system-september-2022

[99] This number may now approach 900,000 as stated in the Governor's Fiscal Year 2024 Budget Briefing Book, p.112.

[100] *Id*. at p. 10.

[101] https://my.visme.co/view/6x6nk6p6-profile-of-the-new-york-state-public-mental-health-system-september-2022 p.10.

[102] Substance Abuse and Mental Health Services Administration. The NSDUH Report (11/19/2013) https://www.samhsa.gov/data/sites/default/files/NSDUH148/NSDUH148/sr148-mental-illness-estimates.htm

[103] *Id.* at p. 5, *citing,* Behavioral Health Statistics and Quality. Results from the 2019 National Survey on Drug Use and Health: Detailed Tables. Rockville (MD): SAMHSA; 2019. https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables

As a provider of service, OMH operates 24 inpatient facilities for civil, forensic and research purposes.[104] There are approximately 3,000 adult and children's beds in the OMH system and 700 forensic beds for people referred for admission from the criminal justice system. [105] In addition, OMH licenses over 100 acute care psychiatric units in general hospitals that have an aggregate capacity of 5,000 beds. [106] In 2019, there were approximately 128,000 admissions to hospitals licensed or operated by OMH. [107] Under the model of care developed by OMH, acute inpatient admissions are largely directed to the Public Health Law article 28 general hospitals with psychiatric units. Longer term care, if clinically indicated, is delivered by OMH state hospitals. Lengths of stay in OMH hospitals can be years in duration, particularly when a patient is referred from the criminal justice system.[108]

Due to the large number of people who are incarcerated and have significant mental health needs, OMH operates an inpatient hospital, the Central New York Psychiatric Center, for people serving sentences. There are also 29 satellite and "outpatient" mental health units with over 1,000 beds across mental health staffed prison programs. [109] People entering state prison are assessed to determine if they require mental health services. There is a range of need between levels 1-4, with level 1 indicating the most serious mental health diagnoses and level 4 the least serious.[110] As of February 1, 2023, there were 31,449 persons in the custody of the Department of Corrections and Community Services ("DOCCS"), a substantial decrease from 2016, for example, when the population was 52,340.[111]

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104 *See* MHL § 7.17.

105 https://my.visme.co/view/6x6nk6p6-profile-of-the-new-york-state-public-mental-health-system-september-2022 p. 24; Forensic Mental Health Services (ny.gov)

106 https://my.visme.co/view/6x6nk6p6-profile-of-the-new-york-state-public-mental-health-system-september-2022 p. 24

107 As reported to the Mental Hygiene Legal Service (MHL § 9.11). MHLS is an auxiliary agency of the Appellate Divisions of State Supreme Court and provides legal services and assistance to patients and residents of mental hygiene facilities pursuant to article 47 of the MHL.

108 Richard Miraglia & Donna Hall, *The Effect of Length of Hospitalization on Re-arrest among Insanity Plea Acquittees*, 39 J. AM. ACAD. PSYCHIATRY & L. 524, 524 (2011) https://jaapl.org/content/39/4/524.long

109 Forensic Mental Health Services (ny.gov) -

110 N.Y. STATE DEP'T OF CORRS. & CMTY. SUPERVISION, UNDER CUSTODY REPORT: PROFILE OF UNDER CUSTODY POPULATION 15 tbl.11 (2020).

111 https://doccs.ny.gov/system/files/documents/2023/02/doccs-fact-sheet-february-2023.pdf. *See also*, Sheila Shea and Robert Goldman, *Ending Disparities and Achieving Justice*

Even as the population of people confined in state correctional facilities has steadily declined, however, the percentage of people on the OMH caseload has increased. Statistics reflect that in 2016, 20% of the DOCCS population in custody at the time were on the OMH caseload. [112] As of January 1, 2020, 23% of individuals in DOCCS custody had an OMH service designation.[113] The percentage had risen again, according to Jack Beck, former director of the Prison Visiting Project at the Correctional Association of New York State, who spoke at the NYSBA annual meeting. As of September 2021, 8,174 people, representing 26% of DOCCS population were on the OMH caseload.[114]

In the community, OMH operates and regulates nearly 800 licensed outpatient programs. Assertive Community Treatment ("ACT") teams, Personalized Recovery-Oriented Services ("PROS") programs, Article 31 clinics, and Day Treatment programs provide treatment and rehabilitation to service recipients in need of community-based support to maintain their mental health.[115] The most common and most largely utilized outpatient services are clinic treatment services, which make up 64 % of all outpatient service programs. [116]

OMH states that community based residential services are provided to maximize access to housing opportunities, particularly for persons with histories of multiple or extended psychiatric hospitalizations, homelessness, involvement with the criminal justice system, and co-occurring substance use disorder.[117] In addition, these services assist individuals in developing functional skills needed

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for People with Mental Disabilities, 80 Alb. L. R. 1037, 1043-1045 (2016-2017) citing statistics on the prevalence of mental illness among people serving sentences in New York State prisons.

[112] Shea & Goldman, *supra,* note 102 at p. 1043

[113] N.Y. STATE DEP'T OF CORRS. & CMTY. SUPERVISION, UNDER CUSTODY REPORT: PROFILE OF UNDER CUSTODY POPULATION 15 tbl.11 (2020).

[114] To address some of the tremendous need for advocacy, Prisoners' Legal Services has established a mental health advocacy program for people who are incarcerated - Mental Health Project – Youth and Veterans – Prisoners' Legal Services of New York (plsny.org) The Mental Health Project provides legal and advocacy services to ensure that incarcerated youth and veterans obtain the mental health care they need and are not subjected to conditions that exacerbate their mental illness. Youth or Veterans can be designated any service level by OMH. There is no minimum OMH service level to request services from the Mental Health Project.

[115] https://my.visme.co/view/6x6nk6p6-profile-of-the-new-york-state-public-mental-health-system-september-2022 at p. 26.

[116] *Id.*

[117] *Id.* at 27.

to live independently and preserve tenure in the community.[118] Residential services are also offered to children to provide short-term residential assessment, treatment, and aftercare planning.[119] In 2019, OMH residential programs provided more than 46,000 beds statewide. Services include Supported Housing, Apartment Treatment, Supported/Single Room Occupancy, Community Residence, Community Residence/Single Room Occupancy and Other (Family Care and Residential Care Centers for Adults).[120] Supported housing is the most independent housing model. OMH contributes a stipend to the program providers which covers rent and supportive services, generally case management. There is generally not a time limit for individuals to reside in supportive housing whereas the treatment and congregate residential programs are limited from one year to 18 months.[121]

Office for People With Developmental Disabilities (OPWDD)

OPWDD is responsible for ensuring that New Yorkers with developmental disabilities "are provided with services including care and treatment, that such services are of high quality and effectiveness, and that the personal and civil rights of persons receiving such services are protected." [122] The services provided by OPWDD are designed to promote and attain independence, inclusion, individuality and productivity for persons with developmental disabilities. [123] Ninety-five percent of the people accessing OPWDD services and supports have Medicaid provided under the Home and Community Based Services ("HCBS") waiver. [124] In 2019, nearly 120,000 people received OPWDD Medicaid services and supports.[125] According to the 2024 fiscal year budget narrative, nearly 131, 000 people receive OPWDD services in New York State.[126] The OPWDD system is largely community-based with the closure of most developmental center

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118 *Id.*

119 *Id.*

120 *Id.*

121 That these programs are intended to be of limited duration is also reflected in OMH regulations governing residential programs for adults. The regulations provide that each "program shall ensure that a discharge planning process for each resident begins upon admission." 14 N.Y.C.R.R. 595.9 (a).

122 MHL § 13.07 (c).

123 *Id.*

124 https://opwdd.ny.gov/providers/home-and-communmnity-based-services-waiver

125 https://opwdd.ny.gov/data

126 Briefing Book | FY 2023 Executive Budget (ny.gov), p.112.

placements. [127] Over one-half of Medicaid enrollees from the OPWDD system live at home or with family care givers. Those people needing residential placement live in community residences licensed or operated by OPWDD.[128] These include "Individualized Residential Alternatives" which may have up to 14 residents and provide room, board and individualized service options.[129] Intermediate Care Facilities ("ICF") are a residential option for individuals with specific medical or behavioral needs whose disabilities severely limit their ability to live independently. [130] Sunmount Developmental Center and the Valley Ridge Center for Intensive Treatment) are classified as ICFs for purposes of the Medicaid program.

Office of Addiction Services and Support (OASAS)

OASAS provides a full array of services to a large and culturally diverse population.[131] OASAS funds, certifies and regulates the State's system of substance use disorder ("SUD") and problem gambling treatment and prevention services, including the direct operation of 12 Addiction Treatment Centers ("ATCs") statewide. The OASAS treatment system serves about 232,000 people each year, with an average daily enrollment of approximately 100,000 across more than 900 certified programs. During the 2018-19 school year, approximately 4,435,000 residents were reached by a one-time, population-based prevention service and 430,000 youth received a direct prevention service. The service continuum includes community-based treatment including inpatient, residential, outpatient, crisis and opioid treatment services, school and community-based prevention services as well as intervention, support, and crisis services. OASAS supports a comprehensive prevention system by supporting approximately 159 providers that implement evidence-based programs and practices in schools and local communities; community-based coalitions that implement environmental strategies; and statewide public awareness campaigns. OASAS also supports six Prevention Resource Centers ("PRCs") across the state that provide training and technical assistance further promoting coalition efforts and local prevention

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127 OPWDD operates two developmental centers located in Franklin County (Sunmount) and Chenango County (Valley Ridge). Statutorily defined as "schools" (*see* MHL§ 1.03[11), OPWDD now refers to these centers as "Intensive Treatment Options" in its continuum of care. The 2024 Executive Budget proposed opening 39 developmental center beds in Rochester.

128 https://opwdd.ny.gov/data Agencies licensed by OPWDD are often referred to as "voluntary providers" and they are non-profit organizations.

129 *See* 14 NYCRR 686.16.

130 *Id., see* 42 C.F.R. part 440-intermediate care facility (ICF/IDD services).

131 *See,* MHL article 19, 14 N.Y.C.R.R. part 800

services. In addition, recovery-focused services include permanent supportive housing as well as peer engagement specialists, family support navigators, youth clubhouses, recovery centers, and regional addiction resource centers.[132]

People with Co-occurring Conditions

Mental Hygiene Law ("MHL") § 5.05 (b) provides that the commissioners of OMH, OPWDD and OASAS shall constitute an inter-office coordinating council ("IOCC"). Consistent with the autonomy of each office for matters within its jurisdiction, the council shall ensure that the state policy for the prevention, care, treatment and rehabilitation of individuals with mental illness and developmental disabilities, alcoholism, alcohol abuse, substance abuse, substance dependence, and chemical dependence is planned, developed and implemented comprehensively. Gaps in services to individuals with multiple disabilities are to be eliminated under state law and no person is to be denied treatment and services because he or she has more than one disability. During her March 16, 2023, presentation to the Task Force, OMH Commissioner Sullivan informed Members that the IOCC has not been active, but she is the incoming chair and intends to revive its mission.

State and Local Government Planning

MHL § 41.16 requires OASAS, OMH, and OPWDD to guide and facilitate the local planning process. As part of the local planning process, Local Governmental Units ("LGUs") develop and annually submit a combined Local Services Plan ("LSP") to all three state mental hygiene agencies through the Mental Hygiene County Planning System ("CPS"). There are 58 LGUs in New York. The LSP must establish long-range goals and objectives that are consistent with statewide goals and objectives.[133] The MHL also requires that each 'O" agency's statewide comprehensive plan shall be based upon an analysis of local services plans developed by each LGU.[134] Each LGU conducts a broad-based planning process to identify the mental hygiene service needs in the community

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[132] The narrative about OASAS is derived from the agency's 2020-2024 Statewide comprehensive plan which is available at: https://www.clmhd.org/img/uploads/OASAS_Statewide_Plan_20_24.pdf

[133] *See,* OASAS 2020-2024 Statewide Comprehensive Plan at p. 9.

[134] MHL § 5.07.

to inform their LSP. In addition to describing their own local priorities and strategies, these plans also inform each state agency's statewide comprehensive planning process. [135]

Investigation

Inspired by the presentation of Stephanie Marquesano, founder and president of "the harris project," and given the obvious complexity of the service delivery system in New York, the Task Force envisions and recommends realizing "seamless systems" change which would have three components:

1) people with needs being able to connect to the system of care at any point, and

2) each point in the various systems of care recognizing their needs and being able to connect them to the proper service providers and supports,

3) with an emphasis on maintaining recovery, with person-centered treatment planning as well as attention to social supports and determinants of health.

Particularly with respect to people with co-occurring disorders, the Task Force endorses the principle that there can be no "wrong door" when seeking services and supports. As stated by Dr. Ken Minkoff, a psychiatrist who has spent the past few decades helping governments around the world reform their mental health systems, too many systems treat people who suffer from both mental health and substance use disorders as the exception, when in fact they are the rule. They make up more than half of all people who seek treatment for one condition or the other. "You can't just create a few specialized programs for that many people," Dr. Minkoff said. "You need to structure your entire system with them in mind."[136]

To learn more about the gaps and challenges in systems, as well as strengths that can be built upon, the Task Force reviewed a sample of recent county mental hygiene self-assessments from 2021 and 2023 to learn about the counties' most recent determinations of their needs and to gain detailed information experienced

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[135] LGU plans for 2020, 2021, and 2023 can be found by county: https://www.clmhd.org/contact_local_mental_hygiene_departments/

[136] *See*, Jeneen Interlandi, Opinion | More Americans Are Dying of Drug Overdoses Than Ever Before - The New York Times (nytimes.com)

at the county levels.[137] In addition, the Task Force heard the testimony provided at the Attorney General Letitia James' hearings on mental health care, held in New York City in September 2022 and Buffalo in January 2023,[138] and reviewed OMH's summary of public comments gathered through its 2021 Statewide Town Halls.[139] Finally, the Task Force was informed by the legislative testimony of its Co-chair, Joseph Glazer which describes how Westchester County strives to create a seamless system of care, but fears the system could implode because service providers are in a staffing crisis and housing providers in a staffing and rent crisis. [140] The following areas of need are explained below.

Workforce Stabilization

Continued workforce shortages persist in mental health treatment systems, affecting inpatient, outpatient, and crisis services, peer supports, care coordination, and cross-systems coordination, as well shortages of culturally competent and bilingual personnel. OMH, OPWDD and OASAS all identify stabilization of their workforces as tremendous challenges. The entire system of care faces collapse when a sustainable workforce cannot be maintained. Thus, for example, the OASAS 2020-2024 Comprehensive Statewide Plan contains the following narrative: "More than half of all LGUs reported unmet Mental Hygiene Workforce Recruitment and Retention needs. While many LGUs reporting unmet workforce needs were in rural areas, LGUs with large urban and suburban populations also reported difficulties filling behavioral healthcare positions. Some LGUs are reporting positions remaining vacant for up to 18 months." [141]

Workforce challenges in mental health treatment systems were further exacerbated by COVID and remain profound. In both inpatient and outpatient

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[137] Albany, Broome, Columbia, Dutchess, Monroe, Nassau, Niagara, New York City, Oneida, Onondaga, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Westchester counties. https://www.clmhd.org/contact_local_mental_hygiene_departments/

[138] In addition to this review, Task Force Members Jeffrey Berman and Sabina Kahn testified at the New York City hearing.

[139] OMH, Local Services Plan and Statewide Town Hall Analysis, September 2022. https://my.vimeo.co/v/1j6edpo3-9zg8pjm

[140] *See,* Glazer testimony, Appendix Document 1

[141] *See,* OASAS 2020-2024 Statewide Comprehensive Plan at p. 11-12. OPWDD reports that stakeholder feedback consistently identifies sustaining the direct care workforce as the most critical issue to support people with developmental disabilities. The OPWDD 2023-2027 strategic plan reports a turnover rate of over 35% of the direct support personnel workforce and a vacancy rate of over 17% in these positions. https://opwdd.ny.gov/strategic-planning

settings, vacancies for psychiatrists and nurse practitioners are causing limits in hospital admissions and community clinic capacity. Counseling and social work positions are also vacant, and vacancies extend as well to peer specialists. Many counties noted the availability of higher pay positions in other fields, and recommended COLA increases. Some OMH-funded positions had been cut, adding to the shortage. These shortfalls are particularly acute as more people with complex needs, exacerbated by the COVID pandemic, are seeking access to services.

Counties further recognized the need for diversity in the workforce to reflect communities served, and many observed as a priority the delivery of culturally competent and linguistically accessible services. This is needed in low-income communities of color who have historically had inequitable access to health services, as well as recently arrived immigrants and refugees. In many immigrant communities, mental health issues are highly stigmatized; to be successful, these services must be culturally competent and sensitive to perceived stigmas.

Also commonly noted as a workforce challenge, was the lack of experienced health home coordinators who must coordinate services for an increasingly complex population. There is a great deal of turnover in these positions. Health home coordinators have higher caseloads than did case managers prior to transition to managed care. The care coordination offered has therefore become less person-centered. Counties also noted the lack of experience with coordinating services across systems of care, affecting populations with co-occurring disorders. The introduction of "Health Home Plus" coordinating services, whereby a coordinator serves people with more intensive needs, has not been sufficient to meet the demand for this critical service.

It was noted that while the promotion and development of telehealth services have helped to alleviate some of the workforce as well universally noted transportation challenges, telehealth is not beneficial for low-income communities that have limited access to technology and the internet. The Task Force further notes the powerful and repeated testimony presented to the New York State Attorney General Letitia James' hearings in September 2022 and January 2023 reviewing crisis in mental health treatment services, in both inpatient and outpatient settings.

To address workforce challenges, the Executive Budget proposed a 2.5% Cost of Living Adjustment ("COLA") Increase and Career Advancement Supports for Mental Health Para-Position. Unfortunately, the lack of COLA increases is so longstanding, that the Governor's proposed increase will not

suffice to boost staffing in these critical programs. Although a COLA statute was enacted in 2006 specifically for mental health treatment and human services providers, COLA increases were not in fact funded in most years since 2006. In the three years in which a COLA was provided, there was a 0.2%, 1.0% and a 5.4% COLA totaling 6.6%, while the consumer price index increased during that period *a total of 35.31%.* (In two other years, there were modest salary increases for mental health treatment programs but no across-the-board increases). Thus, the cumulative, compounded impact of deferred COLA increases is thus over 30% loss in reimbursement, when compared to the increase in inflation, over those 16 years. As a result, most mental health and substance use disorder providers have extreme difficulty hiring and retaining staff positions and many have double digit vacancy rates.

The Governor's historic proposed expansion of mental health services in her FY 2024 Executive Budget, would, in the opinion of the Task Force, have limited impact without increasing funding to existing providers to pay competitive salaries to recruit and retain competent staff. The Task Force, instead, supported the 8.5% COLA recommendation of the Legislature, NYAPRS and other advocates and issued a legislative memorandum for public release on March 16, 2023. The legislative memorandum of the Task Force is reproduced in the Appendix to this report.[142] The Task Force also recommends hiring bonuses for clinicians and peer specialists who have needed bilingual language skills.

The lack of affordable housing is a longstanding problem affecting both the availability of residential supportive housing and independent supportive housing.

Every county sampled reported lack of sufficient affordable housing, with many mentioning the lack of accessibility as an issue as well, preventing adults with psychiatric disability from aging in place, and limiting the housing available to individuals with both mobility impairments and psychiatric disability. Waitlists for independent housing (supported) can extend to years in all regions of New York State. Individuals generally must wait, though for not as long, for congregate staffed or apartment treatment housing. Counties commented that people favor the most independent level of housing. The Task Force notes that this is also a more permanent housing option, in contrast to the transitional congregate housing models.

[142] Task Force Memorandum supporting S. 4007-B, Part DD, A. 3007, Part DD. Appendix Document 8

Problems affecting the supply include the rise in fair market rental prices in most regions of New York, while OMH's reimbursement rates for supported housing have remained static. Landlords leave the OMH housing system because they can charge higher rentals outside that system. Task Force Co-Chair Joseph Glazer's legislative testimony explains the problem concisely with the implications for Westchester County service recipients and providers:

> "Currently the Supported Housing allocation and guidelines for Westchester County provide $1699 for a one bedroom. The median rental rate in Westchester County, is $1796 a month for a one-bedroom apartment. That means that well over 50% of available apartments are not available to our population in need. The minimal increases in rental allowance included the last two years have proven to be insufficient to keep up with skyrocketing rental rates. Our mental health housing programs currently have a waitlist of 750 people on the Support Housing referral list. There are people on our waitlist for housing who have been on the list for up to five years. The average wait time for each program is:
>
> Community Residence – 2 years
>
> Treatment Apartment – 9 months
>
> Supported Housing – 5 years
>
> Beyond the overall insufficiency of the number of allocated beds, there are currently 60 vacant openings in Supported Housing because we cannot find rental apartments willing to accept the amount provides in the rental guidelines. Simply put, this means we have 'residential beds' that exist on paper in our housing system, but they do not actually exist because we cannot find landlords willing to accept the rental rate." [143]

There is also an unmet need for supportive, harm reduction housing for persons with co-occurring psychiatric and substance use disorders. However, "Not In My Back Yard" public resistance can obstruct the development of housing for individuals with psychiatric disability alone or co-occurring disorders. In addition to being directly related to treatment through the OMH system, stable, safe and affordable housing is a crucial social determinant of health. Several counties noted the stress on their communities of color, who suffer inequities in

[143] *See,* Glazer testimony, Appendix Document 1

access to housing for both socioeconomic and historically racial reasons.[144] Many areas of New York remain segregated racially and economically. In high risk, historically marginalized communities, racial strife and extreme rates of poverty all lead to higher stress and increased need for mental health services. Homelessness is greatest among Blacks, and disproportionately so in relation to other populations.

The Empire State Supportive Housing Initiative ("ESSHI"), which awarded up to $25,000 in grants for services and operating costs and was available to all three "O" agencies, awarded its last contracts in 2021 and appears to have had limited impact on the state's overall needs.[145] There is some supportive housing development, with more coming on board, but the eligibility criteria linking to risk of homelessness is perceived by some counties as overly stringent. In addition, ESSHI does not fund capital costs, which has limited the development of sufficient housing to address regional needs. Awards were not based on a statewide assessment of need. Instead, local providers applied for housing that was recognized by the local CoC's determination of need.

Governor Hochul proposes high levels of both capital and operating expenses for supportive housing. Specifically, the Governor's plan includes $890 million in capital and $120 million in operating funding to establish and operate 3,500 new residential units for New Yorkers with mental illness. These units include 500 community residence-single room occupancy units, which provide housing and intensive services to individuals with serious mental illness who are at the highest risk of homelessness; 900 transitional step-down units; 600 licensed apartment units serving individuals who require an intermediate level of services.

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144 *See, e.g.*,
https://www.clmhd.org/contact_local_mental_hygiene_departments/erie_15_county.htm;
https://www.clmhd.org/contact_local_mental_hygiene_departments/newyork_31_county.htm

145 In a March 12, 2023, perspective piece published in the Albany Times Union, Kevin O'Connor, the Executive Director of Joseph's House Shelter in Troy, New York explains that the New York State Supported Housing Program ("NYSSHP"), the first state-funded program, has been left behind and it still receiving about the same level of financial support it received in 1987. The ESSHI program, in contrast, was created in 2016 and pays five times more in service funding than NYSSHP. However, as Mr. O'Connor explains, the state never brought the original NYSSHP in line with ESSHI, and thus "housing programs that began under the NYSSHP umbrella remain chronically underfunded and struggle to sustain themselves." https://www.timesunion.com/opinion/article/commentary-supportive-housing-keeps-people-17830689.php

Also funded through this allocation would be 1,500 supportive housing units, which would serve individuals who have less acute needs but still require support to live in the community. In addition, the plan includes $25 million in capital and $7.3 million in operating costs for 60 community step-down housing units in New York City to serve formerly unhoused individuals who are transitioning from inpatient care.

The Task Force applauds the Governor's commitment to invest in housing. However, given the consistently longer wait lists for supported housing than for congregate models, the balance of funds would be better allocated with the majority for more independent supportive housing. With flexible services that can vary intensity such as mobile teams and peer support, people whose needs may become acute can be well served in independent housing.

The Task Force notes the OMH Rehabilitative and Tenancy Support Services ("1115 Waiver") has been helpful to counties. This waiver increases the accessibility of Supported Housing to individuals with more complex needs by providing the support services necessary to promote stability in the community. For supported housing, this funding leaves more room in the original Supported Housing contracts for much needed rent to obtain more appropriate housing. OMH has included this waiver request in its 2023 package of Medicaid waiver services awaiting CMS approval. [146]

Practitioners on the Task Force have observed, as well, the gaps in access to housing that can exist for individuals who are incarcerated. One important gap is that supportive housing providers rarely interview people for housing during their incarceration. Solutions are needed to facilitate applications for incarcerated persons, such as videoconferencing. In addition, the State has requested CMS approval of a Medicaid waiver 30 days prior to an individual's release from jail or prison, which would include coverage of care coordination services. Individuals with developmental disabilities, psychiatric disability, and/or substance use disorders would qualify for such services. This added support for discharge planning should greatly enhance access to supportive housing for individuals with mental health or co-occurring needs.

Need for more crisis services/stabilization/ crisis respite beds to divert from hospitals and reduce interaction with law enforcement.

[146] This program was initiated in 2022.
https://omh.ny.gov/omhweb/adults/supportedhousing/supportedhousingguidelines.html

Counties are benefitting from the new intensive crisis stabilization centers, such as those in the Hudson Valley, which serve to divert individuals experiencing crisis from emergency room admissions. However, long emergency department waits remain, particularly for individuals with co-occurring SUD, developmental disabilities, or medical needs with mental health needs. More training for people with developmental disabilities, as well as establishing a single point of contact for crisis services for individuals with mental health, SUD, and/or developmental disabilities is greatly desired. With more funding to permit longer stays, crisis centers could do more than divert from inpatient admission. These would be more in the model of crisis residences and crisis stabilization centers. The workforce challenge bears repeating here, as well, as counties see a need for more trauma-informed professionals to respond to mental emergencies. Counties noted good pilot programs where mobile crisis teams work together with law enforcement. Because of workforce challenges, this seems a necessary model to develop, particularly in rural areas. The need for peer specialists to augment crisis services was noted, as well.

Governor Hochul is proposing to establish 12 new comprehensive psychiatric emergency programs providing hospital-level crisis care; creating 42 additional Assertive Community Treatment teams to provide mobile, high intensity services to the most at-risk New Yorkers and eight additional Safe Options Support teams - five in New York City and three in the rest of state - to provide outreach and connection to services for homeless populations with mental illness and substance use disorders.

Coordinating Systems of Care

Mid-Hudson counties have come together to form a region-wide Co-Occurring System of Care ("COSOC") committee to address multiple, complex needs across a variety of behavioral health and other systems. This committee uses the Comprehensive Continuous Integrated Systems of Care ("CCISC") model, an evidenced-based SAMHSA "best practice" model[147] which brings together cross system partners to respond to complexity of needs regardless of where the individual initially touches down. Providers strive to become integrated and co-occurring, but are still constrained by lack of resources and type of licensure. Providers share a vision of a welcoming system of care that expects individuals to have complex needs and is prepared to provide competent

147 Minkoff & Cline, 2004, 2005

integrated treatment and support in an empathic, hopeful, integrated, and strength-based way, a truly no wrong door approach.

Cross system coordination and improved access to care would be further enhanced through increased funding flexibility including the ability to braid and blend funds and dually license treatment and residential programs. Helpfully, the Governor's budget includes dually licensed behavioral health clinics, which will triple in number from 13 to 39. These clinics will offer integrated mental health and substance use disorder services for New Yorkers of all ages on a walk-in, immediate basis, regardless of insurance status.

The need for planning for people with co-occurring conditions is essential to the functioning of a seamless system of care. The Task Force placed a particular focus on co-occurring disorders ("COD") which refers to a diagnosis of one or more mental health disorders plus substance (drug and/or alcohol) misuse and/or addiction. Materials produced by "the harris project" explains that COD involves two diagnostic areas: mental health and substance misuse and/or addiction (as well as the impact of trauma). [148] Mental health disorders commonly associated with COD include:

- mood disorders like depression or bipolar disorder
- anxiety disorders like generalized anxiety disorder, social anxiety, panic disorder
- post-traumatic stress disorder, oppositional defiance disorder
- obsessive-compulsive disorder.[149]

Compared to those who have a mental health disorder or substance misuse and/or addiction alone, people with COD often experience more severe and chronic medical, social, and emotional problems. The challenge is to address both diagnostic areas without compromising the best treatment for either one.[150] Approximately 10.2 million Americans meet the diagnostic criteria each year and it is estimated that approximately 70% of those addicted to substances have

[148] https://theharrisproject.org

[149] http://www.dpt.samhsa.gov/comor/co-occurring.aspx)

[150] http://www.psychologytoday.com/conditions/co-occurring-disorders

COD.[151] As the mental health and substance misuse and/or addiction pieces impact one another greatly, they should be treated with an integrated, comprehensive plan.[152] As stated by "the harris project":

> "many of those diagnosed with COD who seek treatment are often bounced among different programs because each fails to provide a model delivering integrated, comprehensive treatment. Unfortunately, most rehabilitation programs, while claiming to address COD, focus almost exclusively on the substance piece, and most find abstinence to be nearly impossible to maintain because of the unaddressed mental health disorder(s). On the flip side, addressing the mental health piece while still misusing substances compromises the success of any mental health program …"[153]

In her remarks to the Task Force on March 16, 2023, OMH Commissioner Sullivan explained the initiatives undertaken by New York State try make its systems more seamless and break down silos of care. What remains unaddressed, but desperately needed in the view of the Task Force, is for the mental hygiene commissioners and the Department of Health to promulgate integrated service regulations. In pertinent part, the MHL provides:

MHL § 31.02 (f):

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[151] http://www.nami.org/factsheets/mentalillness_factsheet.pdf

[152] https://www.samhsa.gov/disorders

[153] http://www.helpguide.org/mental/dual_diagnosis.htm Statistics cited by "the harris project" are devasting. Every day in the United States, 197 people die because of drug overdose, and another 6,748 are treated in emergency departments ("ED") for the misuse or abuse of drugs. Drug overdose was the leading cause of injury death in 2016. Among people 25 to 64 years old, drug overdose caused more deaths than motor vehicle traffic crashes. In 2012, 33,175 (79.9%) of the 41,502 drug overdose deaths in the United States were unintentional. In 2011, drug misuse and abuse caused about 2.5 million ED visits. Of these, more than 1.4 million ED visits were related to pharmaceuticals. And those numbers continue to rise daily. Nearly 9 out of 10 poisoning deaths are caused by drugs. In 2012, of the 41,502 drug overdose deaths in the United States, 22,114 (53 percent) were related to pharmaceuticals. In 2017 over 72,000 Americans died by overdose. https://theharrisproject.org

> "No provision of this article or any other provision of law shall be construed to require a provider licensed pursuant to article twenty-eight of the public health law or certified pursuant to article sixteen or article thirty-two of this chapter to obtain an operating certificate from the office of mental health if such provider has been authorized to provide *integrated services* in accordance with regulations issued by the commissioner of the office of mental health in consultation with the commissioner of the department of health, the commissioner of the office of alcoholism and substance abuse services and the commissioner of the office for people with developmental disabilities …." (emphasis added). [154]

Regulations have not been proposed by the responsible state agencies forgoing a legislative remedy to redress a significant obstacle to creating a seamless system of care. The Task Force urges the state agencies to adopt integrated service regulations without further delay.

Limited inpatient resources

County self-assessments reveal that the lack of enough inpatient beds. This is a national trend as explained in the 2022 report of the American Psychiatric Association.[155] New York also experienced the repurposing of psychiatric beds in some Article 28 psychiatric units during COVID exacerbating a pre-existing crisis. [156] New York also altered Medicaid to incentivize earlier discharges from acute care settings – hospitals simply are not paid once the individual's needs are no longer acute. At the same time, OMH's intermediate long-term bed admissions now employ a higher criterion for admission. For example, OMH hospital staff may respond to a proposed admission requesting trials of a medication treatment before an admission, but that cannot be completed at the acute care setting. Counties and community providers find that often the acute care hospital discharge planners fail to coordinate with community-based providers to ensure

[154] *See also*, MHL § 32.05 (b)(ii)

[155] *See, supra,* note 36*, The Psychiatric Bed Crisis in the U.S.: Understanding the Problem and Moving Toward Solutions,* p 3. As explained by the APA, access to inpatient psychiatric beds "undergrids local mental health systems, providing essential services to help treat adults or young people who are experiencing mental illness, just like inpatient medical hospitalization serves the most acutely ill."

[156] It should be noted that in many counties, during COVID access to outpatient services decreased even more severely than inpatient.

that services and housing are in place.[157] In addition, there simply may not be enough time, on the Medicaid dollars, to set a discharge plan.[158] Task Force practitioners have also found that hospital staff are not submitting SPOA referrals[159] and HRA 2010E supportive housing applications[160] likely for lack of time. It is essential that hospitals submit applications as early as possible during the patient's psychiatric hospitalization and that step-down programs are available for individuals to await the housing decision.

Governor Hochul proposes new requirements that hospitals responsibly admit and discharge patients, with new, comprehensive standards for evaluation and increased state-level oversight to ensure that new protocols are being used effectively. To ensure the success of these new requirements for discharge planning, a $28 million investment will create 50 new Critical Time Intervention care coordination teams to help provide wrap-around services for discharged patients - from housing to job supports.

Insurance Parity

Many counties noted the need to enforce insurance parity. Outpatient, care coordination, and mobile services are better covered by Medicaid than by private insurers. Governor Hochul's Article VII legislation would close gaps in insurance coverage for behavioral health services and prohibit carriers from denying access to medically necessary, high-need, acute and crisis mental health services for both adults and children, including medications for substance use disorder. This includes eliminating pre-authorization requirements for ACT and mobile crisis services.

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157 https://www.clmhd.org/contact_local_mental_hygiene_departments/
Bronxworks and Center for Community Services, *Improving Care Coordination for Homeless Individuals with Severe Mental Illness in NYC*, p. 4 (February 2022).

158 The APA similarly noted in its 2022 report that utilization review criteria that limit inpatient stay to the minimum "medically necessary" can lead to premature discharge and adverse consequences including relapse, hospital readmission, homelessness, criminal justice involvement and all-cause mortality including suicide. *Supra,* note 86 at p. 31.

159 SPOA is an acronym for Single Point of Access, the system in place to access various OMH housing alternatives. https://www.nyconnects.ny.gov/services/single-point-of-access-spoa-omh-pr-705507562002

160 An application, commonly called the HRA 2010e, must be submitted electronically by an approved provider to the Human Resources Administration's Placement, Assessment and Client Tracking (PACT) Unit in order to apply for supportive housing Approved providers include any NYC shelter, hospital staff, NYC corrections staff, residential treatment program staff or mental health professionals.

Expansion of Peer Specialists and Clubhouses

Clinical care alone is not a complete foundation for recovery for people who have psychiatric disabilities. As Dr. Insel observes, "recovery is not just relief from symptoms, it's finding connection, sanctuary, and meaning not defined or delimited by mental illness"- also framed in his book as "recovery: people, place and purpose." [161] Recovery is a growing process of self-determination that is supported through relationships and social networks. The person, not an illness, is at the center of this process. Peer specialists who have lived experience with psychiatric conditions, as well as training in supporting their peers, are essential to recovery and wellness. [162]

Counties repeated recognized the need for more peer specialists in all aspects of the care system and to support diversion from hospitals. This is also an important theme in the public input provided to OMH through its Town Hall process. According to OMH's summary of public comments from the 2021 Statewide Town Hall, many comments focused on the expansion of peer support services and emphasized the need to devote workforce funding to increase the roles of people with lived experience and paying an adequate living wage. The Task Force strongly advocates for expansion of peer programs, as most effective and motivating for individuals and the best way to engage people to make informed decisions and choices in treatment. Unless choice is supported, even if the person experiences momentary benefit from a medication, the individual's involvement is not likely to last. And for people who do not have support of family or friends, clubhouses are an established way of supporting recovery through supportive community.

The Governor proposes to invest $2.8 million to expand the Intensive and Sustained Engagement Treatment program to offer peer-based outreach and engagement for adults with serious mental illness. The Task Force supports this investment, and would call for greater increases for peer supports, including in

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[161] Insel, *supra,* note 6 at p 160-161.

[162] Harvey Rosenthal's description of the role that peers can play in facilitating successful discharges from hospitals resonated with the Task Force. Mr. Rosenthal referred to this concept as "peer bridging." The role of peer support is especially important when placed into the broader issues described in the APA report, specifically, that "today psychiatric care is complex and encompasses many factors that reflect a struggle to provide compassionate care with diminishing resources and within time frames that are often too short to evaluate treatment response or facilitate meaningful recovery." *See, supra,* note 36, *The Psychiatric Bed Crisis in the U.S.: Understanding the Problem and Moving Toward Solutions,* p 3.

crisis programs and residence to divert from hospitalization, as well as to bridge from hospital to community. The Task Force supports as well, training in crisis planning and psychiatric advance directives as part of the certification curriculum for peer specialists. In this way, individuals can exercise choice in treatments even when undergoing crisis, and thereby avoid traumatizing coercive interventions.

Racial Inequities in Access to Care and Exposure to Trauma

Commenters in OMH's Statewide Town Hall pointed out how vastly disproportionately, it is black and brown children who have lost parents and caregivers, lending a backdrop of trauma to their lives. County systems, as well, recognized the impact of racism and poverty on communities. Public commenters asked, how will OMH systems and crisis stabilization address racial trauma and reacted powerfully to the experience of mandatory treatment: "Get these AOT orders down, and these arrests down, and these fatalities down." Supportive engagement, and supporting safe and accessible housing, person-centered treatments of choice, need to be the pillars of the treatment system. Trauma is also the experience of many refugees who have settled in our state. Many suffer from undiagnosed trauma on account of political turbulence, war, and harrowing personal ordeals, which may affect the approach used to treat substance abuse disorder and/or mental illness and may hinder expected progress in treatment.

Serving the Mental Health Needs of Immigrants and Refugees

There are two obvious hurdles to serving the mental health needs of immigrants and refugees. One is cultural: mental health is a taboo issue in many new American communities, and mental illness is a source of shame in societies with a strong belief in honor versus shame. In addition, Western "talk therapy" is practically unknown outside the Global north. Instead, the family plays a critical role in a person's well-being in many countries and cultures, and as such, involving spouses or close family in the treatment of recent immigrants can help, a practice that is not widely embraced in the United States. Second, access to interpreters is unavailable in the group therapy context so learners of English are often simply excluded from this form of therapy even if it is part of the court-mandated behavioral health regimen. Recently, a Rockland County resident sued the county's drug court and the state court system, accusing court officials of barring him from a diversion program because of his limited English proficiency. As well, some treatment providers do not have easy access to reliable, professional interpretation services for optimum one-on-one mental health care.

Boarding in emergency rooms and an innovative response

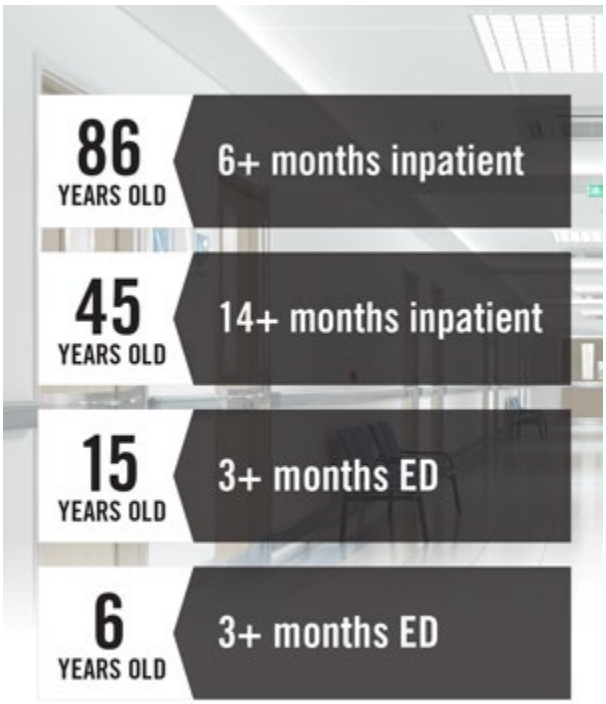
In addition to studying local county mental health self-assessments, the Task Force focused its efforts on the vexing problem of patients boarding in emergency rooms and hospitals as a systems issue.

As explained earlier, the Healthcare Association of New York State ("HANYS") reports that hospitals across the country have reported an alarming rise in patients who become caught in limbo in emergency departments and inpatient units for weeks, months and even years after they are medically ready for discharge. These delays most often occur due to a lack of care options, the inability to pay for post-discharge care and/or administrative gridlock. Complex case discharge delays, also known as bed blocking or boarding, are devastating for patients, exacerbate bed shortages and result in enormous, unnecessary costs. HANYS described the impact upon patients as follows:

> "Unnecessary hospital stays can lead to an irreversible decline in functional status and negatively impact psychological well-being, especially for older adults and children. Patients living in limbo in the hospital environment lose their autonomy, become socially isolated and lack access to the intellectual and physical activity necessary to thrive. Discharge delays also exacerbate hospital bed shortages, risk staff safety and well-being and result in extraordinary costs to our healthcare delivery system." [163]

HANYS' 2021 white paper, *The Complex Case Discharge Delay Problem*,[164] provided an overview of the long-standing challenges facing real people and hospitals and highlighted real cases to emphasize the magnitude of the problem. This graphic is copied from the HASNY and lends a powerful image:

[163] https://www.hanys.org/communications/publications/scope_of_complex_case/
[164] https://www.hanys.org/communications/publications/complex_case_discharge_delays/



To learn more about the scope of complex case discharge delays in New York, HANYS conducted a three-month data collection pilot with hospitals statewide. In 2023, HANYS released a summary of the pilot findings and a framework to focus solutions. The data affirms that the fiscal cost of the problem is enormous. Fifty hospitals reported 992 patients experiencing discharge delays of more than two weeks between April 1 and June 30, 2022, at an estimated total cost of $167 million, or an average of $168,000 per case. Individuals who had an undocumented non-citizen status (most commonly uninsured or emergency Medicaid) experienced the longest average delayed days, followed by those with Medicaid fee-for-service. HANYS developed the following framework to focus efforts to ensure that patients no longer languish in hospitals for months to years after they are ready for discharge:

- prevent unnecessary hospitalization;
- intervene early when patients at high risk of delay arrive at the hospital;
- respond to patient needs during unavoidable extended delays; and
- increase visibility of delays in access to care.

The Task Force notes unique concerns about boarding and its impact upon children. This issue is not lost on New York State. In 2011, New York State convened a Respite Care Services Workgroup [165] at the behest of the Committee on Cross-systems Youth.[166] Group membership included the Council on Children and Families, OPWDD, DOH and OMH, among other state agencies. The workgroup noted that emergency respite availability is virtually non-existent for cross-system youth and consequently, children in crisis may be picked up by law enforcement or present at hospital emergency rooms. A report was rendered in April of 2011 and is included in the Appendix to this report.[167] Interim recommendations included strengthening respite care services as a preventative strategy within the system of care to meet the needs of high-risk youth. As far as the Task Force is aware, the working group did not issue any other reports and its interim findings and recommendations were never implemented.

Massachusetts ABC legislation

The Massachusetts Mental Health "ABC" Act – Addressing Barriers to Care[168] – was passed unanimously in 2022 could be a model for New York and other states to follow. The Commonwealth's legislation attempts to reform the service delivery system with the goal that everyone who needs mental health care will be able to receive it. [169] Here are six initiatives among any that are identified as priorities in Massachusetts:

- facilitate the development of interagency initiatives that: (i) are informed by the science of promotion and prevention; (ii) advance health equity and trauma-responsive care; and (iii) address the social determinants of health;
- develop and implement a comprehensive plan to strengthen community and state-level promotion programming and infrastructure through training,

[165] Respite is a term of art and means intermittent, temporary substitute care of a person on behalf of a caregiver who requires relief from the responsibilities of daily caregiving. *See, e.g.*, 14 NYCRR 635-10.4.

[166] The term "cross system youth" is understood by the Task Force to include children eligible to be served by more than one state or local agency and would commonly include children with multiple disabilities.

[167] *See* Appendix, Document 9

[168] Session Law - Acts of 2022 Chapter 177 (malegislature.gov)

[169] Mental Health ABC Act signed into law in Massachusetts | WWLP

technical assistance, resource development and dissemination and other initiatives;

- advance the identification and dissemination of evidence-based practices designed to further promote behavioral health and the provision of supportive behavioral health services and programming to address substance use conditions and to prevent violence through trauma-responsive intervention and rehabilitation;
- collect and analyze data measuring population-based indicators of behavioral health from existing data sources, track changes over time and make programming and policy recommendations to address the needs of populations at greatest risk;
- coordinate behavioral health promotion and wellness programs, campaigns and initiatives;
- hold public hearings and meetings to accept comment from the public and to seek advice from experts, including, but not limited to, those in the fields of neuroscience, public health, behavioral health, education and prevention science.[170]

The law takes specific aim at emergency room boarding and requires ER's to have a behavioral health clinician available. It will also create an online portal to speed up care for patients. [171] The portal "enables health care providers, health care facilities, payors and relevant state agencies to access real-time data on children and adolescents who are boarding, awaiting residential disposition or in the care or custody of a state agency and are awaiting discharge to an appropriate foster home or a congregate or group care program." Among other things, the online portal shall include information on the specific availability of pediatric acute psychiatric beds, crisis stabilization unit beds, community-based acute treatment beds, intensive community-based acute treatment beds, continuing care beds and post-hospitalization residential beds.

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[170] Session Law - Acts of 2022 Chapter 177 (malegislature.gov) sec. 1

[171] The Massachusetts statute offers a definition of boarding. Boarding means "waiting not less than 12 hours to be placed in an appropriate therapeutic setting after: (i) being assessed; (ii) being determined in need of acute psychiatric treatment, crisis stabilization unit placement, community-based acute treatment, intensive community-based acute treatment, continuing care unit placement or post-hospitalization residential placement; and (iii) receiving a determination from a licensed health care provider of medical stability without the need for urgent medical assessment or hospitalization for a physical condition."

The Massachusetts ABC law also requires the state to develop a similar portal for adults. The statute provides:

> "The secretary of health and human services shall facilitate psychiatric and substance use disorder inpatient admissions for adults seeking to be admitted from an emergency department or hospital medical floor by developing and maintaining a confidential and secure online portal that enables health care providers, health care facilities and payors to conduct a real-time bed search for patient placement. The online portal shall provide real-time information on the specific availability of all licensed psychiatric and substance use disorder inpatient beds that shall include, but not be limited to: (i) location; (ii) care specialty; and (iii) insurance requirements…"[172]

The Task Force urges New York to similarly hold public hearings elevate the issue of boarding in ERs and hospitals because there is a crisis that needs to be remedied. The human and fiscal cost is enormous. The very existence of the complex case discharge delay problem as framed by the APA and HANYS is evidence that our systems of care are broken.

Recommendations

- State and local authorities administering programs for people with mental disabilities should promote "seamless systems" change which would have three components: 1) people with needs being able to connect to the system of care at any point; 2) each point in the various systems of care recognizing their needs and being able to connect them to the proper service providers and supports; and 3) emphasis on maintaining recovery, with person-centered treatment planning as well as attention to social supports and determinants of health.
- Promote a seamless system that includes and addresses co-occurring disorders, recognizing that individuals in need frequently have multiple or overlapping needs and disabilities.
- Seek alternatives to coercive interventions and promote non-hospital community voluntary crisis stabilization programs.

[172] Session Law - Acts of 2022 Chapter 177 (malegislature.gov) sec. 2.

- Support "peer bridging" as a link between the hospital and a successful discharge plan.
- Promote community investment in supported housing units.
- Recommend that the Office of Mental Health ("OMH"), the Office for People With Developmental Disabilities ("OPWDD"), and the Office of Addiction Services and Supports ("OASAS") and the Department of Health to collaborate and adopt integrated service regulations without further delay.
- Recommend that OMH and OPWDD operate or fund respite beds for children and adults with disabilities to avoid boarding in hospital emergency rooms.

D. *Criminal Justice*

"America Has Made Mental Illness a Crime"

As observed by Task Force member Patricia Warth, quoting author Alicia Roth, "America as Made Mental Illness a Crime."[173] During the last quarter of the 20th century, the dramatic reduction of inpatient mental health care capacity was accompanied by an equally dramatic increase in criminalization and incarceration.[174] This increase in incarceration was historically unprecedented and occurred after decades of relative stability in incarceration numbers and rates.[175] Yet four decades of "tough on crime" rhetoric led to harsher sentencing policies and the criminalization of mental illness and substance dependence. This rhetoric is wholly inconsistent with crime victims' views that diversion - as

[173] Warth, *supra* note 32, *Unjust Punishment: The Impact of Incarceration on Mental Health*, 95 Feb-N. Y. St. B. J. 11-12, *citing* Alisa Roth, *Insane: America's Criminal Treatment of Mental Illness* 81.

[174] In 1973, the United States incarcerated adults at a rate of 161 per 100,000 adults; by 2007, this rate had quintupled to 767 per 100,000. In absolute terms, "the growth in the size of the penal population has been extraordinary; in 2012, the total of 2.23 million people held in U.S. prisons and jails was nearly seven times the number in 1972." See Warth, *supra* note 11, National Research Council 2014, The Growth of Incarceration in the United States: Exploring Causes and Consequences, Washington,
DC: The National Academies Press, https://doi.org/10.17226/18613, at 33, 35-36.

[175] Sol Wachler & Keri Bagala, *From the Asylum to Solitary: Transinstituionalization*, 77 Alb. L. Rev. 915 (2014).

opposed to incarceration - is the preferred outcome for an accused person,[176] and also resulted in over-policing and over-criminalizing drug possession and "quality of life" issues, which in turn led to the U.S.'s overreliance on arrest, severe penalties, and increased incarceration.[177] Today, "[p]olicing, arrest, and criminal punishment have become the default response not only to violence and other harms, but also to poverty, mental health crisis, drug use and addiction, HIV and other health conditions, and school discipline." [178] Our nation's overreliance on arrest and incarceration, combined with the failure to provide meaningful treatment options for people with mental illness, has resulted in far too many people with mental health conditions being ensnared in our criminal legal system. The statistics are stark:

- The National Alliance on Mental Illness estimates that between 25% and 45% of all Americans with mental illness will be incarcerated at some point in their lives. In contrast, only 6.6% of the general population will experience incarceration.[179]
- People with mental illness in the U.S. are 10 times more likely to be incarcerated than they are to be hospitalized.
- More than 70% of people in U.S. jails and prisons have at least one diagnosed mental illness or substance use disorder or both, and up to a third of incarcerated people have a serious mental illness.
- The problem is most acute for women who are incarcerated; a 2017 study found that 20% of women in jail and 30% in prisons had experienced "serious psychological distress" in the month before the survey, compared to only 14% of jailed men and 26% of imprisoned men.

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[176] Alliance-for-Safety-and-Justice-Crime-Survivors-Speak-September-2022.pdf (allianceforsafetyandjustice.org)

[177] Warth, *supra* note 32, *Unjust Punishment: The Impact of Incarceration on Mental Health*, 95 Feb-N. Y. St. B. J. at 12.

[178] *Id., quoting,* Andrea J. Ritchie and Beth E. Ritchie, The Crisis of Criminalization: A Call for a Comprehensive Philanthropic Response, Barnard Center for Research on Women at 3 (2017), https://bcrw.barnard.edu/wp-content/nfs/reports/NFS9-Challenging-Criminalization-Funding-Perspectives.pdf.

[179] Megan J. Wolff, PhD MPH, Weill Cornell Medicine, Psychiatry, "Fact Sheet: Incarceration and Mental Health," May 30, 2017, available at: Fact Sheet: Incarceration and Mental Health | Weill Cornell Medicine Psychiatry

• The numbers of mentally ill in carceral settings continues to increase. In 2010, approximately 30% of people jailed at Rikers Island had a mental illness; by 2022 it had risen to 50%. .[180]

The "tough on crime" rhetoric that fueled mass incarceration also fostered a mistaken belief that rehabilitation is ineffective, often leaving punishment as the primary focus of our criminal legal system.[181] As our jail and prison population continued to increase, the will for a fiscal investment in rehabilitation and treatment programs waned, as did the will to fund mental health care both in and out of prison.[182] As observed by CCJ and COSCA, "For too many individuals with serious mental illness, substance abuse disorder, or both, the justice system is the de facto entry point for obtaining treatment and services. There are many causes, not the least of which is the criminalization of mental illness and the lack of alternative approaches and resources to support the diversion of individuals from the courts and into treatment."[183]

Toward More Humane Treatment of People with Mental Illness: Diversion and Deflection

Patricia Warth poignantly observes that America must develop a commitment to humanely care for, rather than criminalize people with mental illness and she says doing so asks us to address two questions: (1) who are we incarcerating and (2) how are we incarcerating them?[184]

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[180] People with mental illness are overrepresented in New York State's largest jail system, the New York City Department of Corrections. More than half (52%) of the people in the New York City Department of Correction's custody are recommended for mental health services, and in 2020, an average of 17% of incarcerated people were diagnosed with a "serious mental illness". New York City Comptroller. (March 2021). FY 2022 Agency Watch List: Department of Correction. Available at: https:// comptroller.nyc.gov/wp-content/uploads/documents/Watch_ List_DOC_FY2022.pdf

[181] Mental health care on Rikers: New York's largest psychiatric provider - City & State New York (cityandstateny.com)

[182] Warth, *supra* note 32, *Unjust Punishment: The Impact of Incarceration on Mental Health*, 95 Feb-N. Y. St. B. J. at 13.

[183] *State Courts Leading Change*, Report and Recommendations (October 2022) p 10.

[184] Warth, *supra* note 32, *Unjust Punishment: The Impact of Incarceration on Mental Health*, 95 Feb-N. Y. St. B. J. at 15

Regarding the first question, the Task Force urges implementation of reforms to dramatically reduce the number of people with mental illness who are arrested and processed through our criminal legal system and, for those people who are arrested, reduce the reliance on incarceration. Such reforms must include the codification of mental health courts in New York State; decriminalizing conduct that is a result of untreated mental illness, such as substance abuse, homelessness, and vagrancy; deflecting people from the criminal legal system before charges are filed, at the point of police contact; and importantly, expanding judicial diversion options for people who become entangled in the criminal legal system because of their health conditions, so that justice-involved individuals can be diverted to treatment, rather than incarceration.[185]

Investing in treatment courts and addressing the root causes that drive criminal behavior will save the state money. According to the Office of Court Administration, for every $1 invested in treatment courts, the state produces $2.21 in benefits, which comes to a net savings of $10,330 per participant over five years[186]. When accounting for the community impact beyond the savings of reduced incarceration and court system costs, like health and child welfare, the Center for Justice Innovation predicts that investment in diversion yields a far more staggering return, potentially saving the state $10 for every $1 invested. This savings is especially urgent in New York City, where taxpayers spend over $556,000 per year for the incarceration of a single individual. In the immediate term, investing in up-front costs to achieve savings in future years is exactly the kind of smart policy approach New York should be taking.

New York's pending Treatment Not Jail Act ("TNJ")[187] legislation is a much-needed evidence-based reform for judicially diverting individuals who become entangled in the criminal legal system due to their untreated functional impairment – be it a mental health condition, substance use disorder or other cognitive or intellectual disability. Significantly, NYSBA endorsed TNJ in a May 13, 2022, memorandum in support. [188] TNJ would amend New York's 2009 judicial diversion/drug court statute as codified in Criminal Procedure Law (CPL)

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[185] *Id.*

[186] New York State Unified Court System, The Future of Drug Courts in New York State: A Strategic Plan (2017), https://www.nycourts.gov/legacyPDFS/courts/problem_solving/drugcourts/The-Future-of-Drug-Courts-in-NY-State-A-Strategic-Plan.pdf.

[187] S. 1976-Ramos/A.1263-Forrest-

[188] *See,* Appendix document 10

article 216 and expand eligibility beyond substance use disorders and limited specified crimes. Under TNJ, mental health courts will also be codified into law, be available for any charged offense, and applicable not only to substance use disorders, but also to mental health conditions or other disabilities so long as the individual's "functional impairment" contributed to their pending charges. TNJ also expands and guides judicial discretion to divert a person from incarceration to treatment; incorporates treatment court best practices including harm reduction, adherence to clinical opinions, person-centered treatment, and voluntary participation; offers pre-plea participation in treatment; ensures equity, due process, and procedural justice in treatment courts; and establishes diversion parts in every county in New York State. Importantly, TNJ requires the presiding judge to engage in a public safety analysis based on clinical evaluation of potential participants and reflecting on the current case to determine whether a treatment mandate is in both the public and individual's best interests. The bill has the potential to address many of the concerns identified in the *Leading Change* report and acknowledges that evidence-based diversion courts work and significantly reduce recidivism.

The goal of deflecting people from the criminal legal system at the point of police contact is one shared by the Biden administration. In March 2022, the White House Office of National Drug Control Policy ("ONDCP") announced release of the Model Law Enforcement and First Responders Deflection Act to encourage all states to develop and use deflection programs-*i.e.*, programs that deflect people with a mental disability away from the criminal legal system and to evidence-based-treatment heard reduction, recovery and prevention services. [189] The Task Force urges examination of this Model Act as a potential source of legislation in New York that can improve policing in a manner that not only saves lives, but also diminishes the number of people with a mental disability caught up in our criminal legal system.

For the second question of how we incarcerate, the Task Force maintains that society must reject the notion that rehabilitation does not work and shift the focus of our prisons and jails from punishment to rehabilitation and treatment. We must also hold jails and prisons accountable for their treatment of incarcerated people by, among other things, requiring accurate reporting and rejecting practices

[189] *White House Announces State Model Law to Expand Programs that Defect People with Addiction to Care, available at:* White House Announces State Model Law to Expand Programs that Deflect People with Addiction to Care | ONDCP | The White House

that are not evidence-based, such as solitary confinement.[190] A starting point is acknowledging the failure to fully implement the 2008 SHU exclusion legislation and the 2021 Humane Alternatives to Long-Term ("HALT") Solitary Confinement Act and requiring the Department of Corrections and Community Supervision ("DOCCS") to meaningfully implement these critically important reforms.[191] As so aptly stated by our Task Force member, Ms. Warth:

> ":.. we must recognize that the solution to caring for people with mental illness before they become ensnared in the criminal legal system--a network of community mental health centers with a single point of entry--has existed for decades but has never been adequately funded. It is time to commit the fiscal resources necessary to break the cycle of failure that has plagued our nation and to meaningfully care for our most vulnerable citizens." [192]

Reforming the Competency to Stand Trial System

The October 22, 2022, *Leading Change* report also identified as a priority reforming the competency to stand trial system. The report observed that nationally, "large numbers of defendants, including many who are charged with misdemeanors or non-violent felonies, spend excessive time in jail awaiting mental health evaluations and competency restoration, often staying longer in custody than they would have if they had been convicted of the crime, creating unnecessary cost that could be reinvested in community treatment. Those that then go through a restoration process often emerge legally competent, but remain untreated, and are returned to their communities with a poor prognosis for the future." [193] *Leading Change* recommends: 1) reserving the competency process, which in New York is codified at article 730 of the CPL, for defendants charged with the most serious crimes; 2) creating competency dockets that facilitate access to appropriate diversion and outpatient restoration services; 3) active management

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[190] Warth, *supra* note 32, *Unjust Punishment: The Impact of Incarceration on Mental Health*, 95 Feb-N. Y. St. B. J. at 15

[191] *See*, Correctional Association of New York Releases Report on Implementation of HALT Solitary Confinement Law — Correctional Association of New York A lawsuit has been filed challenging the failure to implement the HALT law and class certification is sought. Lawsuit seeks compliance from state prisons with HALT Act | News 4 Buffalo (wivb.com)

[192] *Id.*

[193] *State Courts Leading Change*, Report and Recommendations (October 2022) p 25.

of competency cases to avoid an individual languishing in jail and decompensating; and 4) requiring competency hearings to be scheduled and held without delay at every juncture.[194]

The Task Force recommends changes to the Criminal Procedure Law such as those advanced in a bill proposed by the New York State Association of Counties and the Conference of Local Mental Hygiene Directors to amend CPL 730. [195] The current provisions of this law have resulted in the diversion of scarce resources to the wasteful attempt to prepare mentally ill people to stand trial rather than helping them to receive the treatment they need. In New York State, for example, the cost of inpatient restoration services by OMH and OPWDD are charged to the counties currently at the rate of approximately $1,100 per day.[196] Consequently, local governmental units are forced to expend hundreds of thousands or even millions of dollars, in failed attempts at restoration, particularly for defendants who may have intellectual disabilities or dementia. Often judges will order such restoration on the mistaken belief that they are helping a defendant to receive treatment leading to recovery.

If enacted, the bill would update and modernize article 730 to eliminate provisions which have been deemed unconstitutional and would 1) require that the reports of professionals examining the defendant include the examiner's professional opinion of a reasonable possibility that the person can be restored; 2) create a definition of restoration services to make it clear that restoration is not aimed at recovery but simply at making the defendant legally able to stand trial; 3) delete the provision that the DA must agree to outpatient restoration so a court can make this decision independently and (4) allow the conversion of the defendant from a criminal status to a civil status so the defendant can receive mental health treatment leading to recovery. [197]

All that said, a functioning competency restoration system requires OMH and OPWDD to provide appropriate services on an inpatient and outpatient basis. On

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[194] *Id.*

[195] A. 8402A/S.7461A(2022).

[196] The New York State statute governing the commitment of defendants who lack capacity to assist in their own defense is codified at Criminal Procedure Law ("CPL") article 730. *See People v Schaffer*, 86 N.Y. 2d 460 (1995). The costs of article 730 commitments are a county charge. See MHL § 43.03 (c). Until 2020, the State only passed on half of the cost of these services to localities. In 2020, the State began charging the full charge of approximately $1,000 a day for in-patient restoration.

[197] A. 8402A/S.7461A(2022).

the inpatient side, a shortage of bed capacity within OMH and OPWDD has caused people adjudicated as incapacitated to languish in local jails awaiting restoration services in state facilities. As an example, in January of 2023, MHLS commenced three proceedings in State Supreme Court on behalf of individuals determined to lack capacity who were confined at the Chenango County Correctional Facility.[198] Two of the individuals had been previously ordered by criminal court to the custody of OMH for restoration and the other individual was ordered to the custody of OPWDD. One of the individuals determined to be incapacitated had been waiting 41 days and the other 52 days to be transferred to the custody of OMH. The individual ordered to the custody of OPWDD had been waiting 218 days for an OPWDD bed and from the time of his arraignment had spent over 494 days in the county jail. OMH and OPWDD both maintained that there was a bed shortage that prevented them from taking timely custody of the individuals. Ultimately, the proceedings were withdrawn when OMH and OPWDD agreed to take custody of the individuals pursuant to the court orders and article 730 of the CPL In addition to the Chenango County proceedings, similar cases were commenced in 2022 in Rensselaer County by MHLS and in Putnam County by DRNY on behalf of CPL 730 respondents committed to the custody of OPWDD.[199]

The cases and investigations proceeding them identified a systemic issue in New York State. Both OMH and OPWDD who receive defendants found to lack capacity and assist in their own defense for restoration services were at capacity in their forensic facilities. OMH, as a matter of policy, receives all CPL 730 respondents for restoration in one of four secure facilities. [200] OPWDD operates

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198 Index numbers 2023- 00005001, 00005002, 00005003

199 Putnam County Sup Ct, Index No: 500954/2022; Rensselaer County Index No: 2022 – 272453. Commissioner Sullivan informed the Task Force during her March 16, 2023, presentation that OMH would open additional forensic beds at the Rochester Psychiatric Center to alleviate the delays experienced in placing article 730 respondents. Commissioner Sullivan also stated that in 2022 there was a 20% increase in article 730 commitment orders issued by local criminal courts.

200 Forensic Mental Health Services (ny.gov) - the facilities are: the Northeast Regional Forensic Facility, Kirby Forensic Psychiatric Center, Mid-Hudson Forensic Psychiatric Center and the Rochester Psychiatric Center Forensic Unit. Confinement of 730 respondents in secure facilities raises constitutional concerns. A person who has been indicted, but not yet convicted, should not be confined in a setting which is more restrictive than necessary to achieve the purpose for which the individual is confined (*see, Jackson v Indiana*, 406 U.S. 715; *McGraw v Wack*, 220 A.D.2d 291; *People ex rel. Jesse F. v Bennett*, 242 A.D.2d 342 [2d Dept 1997]).

two inpatient developmental centers which may receive 730 respondents for restoration - the Sunmount Developmental Center and the Valley Ridge Center for Intensive Treatment). Litigation in other jurisdictions has resulted in settlements and court orders establishing that a State's failure to provide timely competency evaluations and restoration services to individuals with disabilities who languish in city and county jails, violates substantive due process rights guaranteed under the 14th Amendment to the United States Constitution[201] A new lawsuit has been commenced in Oklahoma. [202]

CPL section 730.60(1) provides, in part, that when a local criminal court issues a final or temporary order of observation or an order of commitment, it must forward such order and a copy of the examination reports and the accusatory instrument to the Commissioner, and, if available, a copy of the pre-sentence report. Upon receipt thereof, the Commissioner must designate an appropriate institution operated by the department of mental hygiene in which the defendant is to be placed. The sheriff must hold the defendant in custody pending such designation by the Commissioner, and when notified of the designation, the sheriff must deliver the defendant to the superintendent of such institution. There is no time limit by which the Commissioner must make a designation and the provision is particularly onerous and constitutionally infirm when, as described above, the Commissioners fail to make a timely designation leaving a defendant found to be incapacitated languishing in jail. The Task Force recommends that article 730 be amended to require that a designation by the Commissioners occur by a date certain. Until that time and where a court is ordering an individual to the custody of OMH or OPWDD for restoration services, the agencies should be transparent

[201] ACLU-PA Settles Lawsuit Over Unconstitutional Delays in Treatment for Hundreds of Defendants With Severe Mental Illness | ACLU Pennsylvania (aclupa.org); *Trueblood v Washington State Dept. of Social and Health Services,* 73 F. Supp 3d 1311 [WD Wash 2014 - finding that wait times to admit those ordered to receive competency restoration services beyond 7 days are constitutionally suspect. *Trueblood* has extensive history beyond the scope of this report. Further history and a summary of the proceedings can be found at *Trueblood v. Washington State Dep't of Soc. & Health Servs*., 822 F.3d 1037 (9th Cir. 2016).

[202] https://www.oklahoman.com/story/news/2023/03/05/lawsuit-alleges-jail-inmates-in-oklahoma-receive-no-treatment-for-mental-illness/699

and report to the court system if facilities are at capacity or if substantial delays can be anticipated.[203]

The Task Force also urges that renewed consideration be given to outpatient restoration. With a 2012 chapter amendment to CPL 730,[204] New York joined the majority of other states that allow for outpatient restoration of capacity.[205] Commentators have suggested that outpatient restoration may offer the most promise for individuals with disabilities in the criminal justice system if all of the following apply: (a) the community has a program to restore competency that is suitable for the treatment needs of the defendant; (b) the program provides intensive, individualized competency training tailored to the demands of the case and the defendant's particular competency deficits; (c) the defendant has a stable living arrangement with individuals who can assist with compliance with appointments and with treatment; and (d) the defendant is compliant with treatment.[206] In New York, OMH has issued policy guidance on outpatient restoration, although outpatient restoration remains an underutilized remedy.[207] Commissioner Sullivan informed the Task Force that OMH would be interested in working with NYSBA to promote outpatient restoration particularly since there is enhanced funding for community services.[208] The Task Force observes that outpatient restoration may find more use, and avoid a potential constitutional

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[203] The same should be true for commitments under section 330.20 of the CPL and article 10 of the MHL - the discrete commitment statute for sex offenders nearing anticipated release.

[204] Assemb. B. 9056-D, 235th Reg. Sess. (N.Y. 2012) (enacted).

[205] *See* Reena Kapoor, *Jail-Based Competency Restoration*, 39 J. AM. ACAD. PSYCHIATRY & L. 311, 311 (2011).

[206] *Placement of Individuals found Incompetent to Stand Trial: A Review of Competency Programs and Recommendations* 25-26 (Disability Rights Cal., Paper. No. CM52.01, 2015).

[207] OFF. OF MENTAL HEALTH, OMH GUIDANCE FOR IMPLEMENTATION OF OUTPATIENT COMPETENCY RESTORATION (OCR) 1 (2013). *See* Ben Hattem, *How New York's Mentally Ill Get Lost in Courts, Jails and Hospitals*, ALJAZEERA AM. (July 27, 2015), http://america.aljazeera.com/articles/2015/7/27/ny-mentally-ill-get-lost-in-the-justice-system.html ("OMH has not made progress on implementing an outpatient restoration program.").

[208] The Commissioner's comments when read with Joseph Glazer's legislative testimony illustrates the potential for outpatient models of support. Mr. Glazer states that "we should be considering alternatives to the triggering of CPL 730, and allowing crisis, respite and enhanced and intensive community-based services to be utilized before a person is deemed CPL 730 incapacitated, which results in their hospitalization and long delays, in the justice system." Appendix Document 1

challenge, if the statutory requirement that the prosecutor consent to the order of outpatient restoration be amended to allow for notice to the people and an opportunity to be heard prior to the entry of the order.

Lastly, forensic hospitals treating individuals under a 730 order of commitment do not typically engage in *any* discharge planning. This glaring missed opportunity is extremely harmful to incarcerated whom after multiple months, are transferred back to local jails who must begin discharge planning efforts from scratch putting these individuals at the end of a waitlist for intensive mental health services and housing options. It is critical that forensic hospitals treating people under a CPL 730 order engage in meaningful and appropriate discharge planning well in advance of a return to fitness. Such planning may include the filing of a Single Point of Access ("SPOA") application seeking Assertive Community Treatment ("ACT") or Intensive Mobile Treatment ("IMT"), as well as a supportive housing application, noting that the failure to make such referrals in a timely manner is disadvantageous to the individual's future community stability and safety.

Practice considerations for article 730

In 1988, the Westchester County Supreme Court struck down the automatic 90-day commitment authorized by section 730.40 (final orders of observation) as unconstitutional in the case of *Ritter v. Surles*.[209] The state officer defendants (then OMH and OMRDD) elected not to appeal the order entered in *Ritter* and instead instituted a policy in OMH facilities hospitals requiring a defendant to be discharged within 72 hours following remand by the criminal court unless the defendant meets the criteria for either a voluntary or an involuntary admission to the hospital pursuant to article 9 of the MHL. In contrast, OMRDD did not immediately adopt any published regulations or policies concerning the retention, care, and treatment of defendants remanded to the Commissioner's custody pursuant to CPL section 730.40. Currently, the OPWDD Bureau of Institutional and Transitional Services ("BITS") makes a placement recommendation for the defendant. The defendant may be admitted to a developmental center pursuant to article 15 of the MHL, but more likely will be referred for community-based services. The statute has never been amended to reflect the *Ritter* decision. In practice. Town and village justices, county court judges, prosecutors, and defense attorneys in New York are often not aware of *Ritter v. Surles* and the fact that there is a declining infrastructure of in-patient beds to receive criminal defendants. *Ritter* should be codified, and the 90-day automatic commitment repealed.

[209] 144 Misc. 2d 495.

The current CPL article 730 was enacted in 1970. In 1972, the U.S. Supreme Court held in *Jackson v. Indiana*[210] that a person charged 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 confinement 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.[211] The constitutional limitation on the confinement of an incapacitated criminal defendant as enunciated by the Supreme Court in *Jackson* has never been codified in New York. Currently, the only temporal limitation of the permissible period in New York of an article 730 retention is that the retention "must not exceed two-thirds of the authorized maximum term of imprisonment for the highest-class felony charged in the indictment."[212] Upon reaching the two-thirds maximum, the indictment is dismissed, and the defendant may only continuously be retained as a civil patient. Currently, rights guaranteed by *Jackson* may be vindicated only through motion practice, which may be commenced by the defendant or the Commissioner. However, albeit rarely, District Attorneys will also commence *Jackson* motions in some cases to relieve counties of the burden of paying the cost of article 730 confinement. It is time for article 730 to be examined by the legislature. New York should have a maximum period of court-imposed retention for restoration that has a nexus to social science research and that also considers the needs of special populations, such as those with intellectual disabilities or dementia.[213]

Court rules implementing CPL article 730 need updating.[214] Currently, the regulations contemplate commitment only to the custody of OMH.[215] The regulations should be amended to recognize that a person can be committed to either OMH or OPWDD. Also, references in part 111 to the "Mental Health

[210] 406 U.S. 715
[211] *Id*. at 738.
[212] CPL 730.50
[213] *See*, Shea & Goldman, *supra,* note 103, *Ending Disparities and Achieving Justice for Individuals with Mental Disabilities*, 80 Alb. L. Rev. 1037 (2016-2017).
[214] See, 22 N.Y.C.R.R. 111.1-111.8.
[215] 22 N.Y.C.R.R. 111.2.

Information Service" should be changed to "Mental Hygiene Legal Service." Section 111.8 of the rules address official forms. The regulations provide that "[f]orms promulgated by the Chief Administrator of the Courts and the Commissioner of Mental Health, or either of them, shall be the official forms for uniform use throughout the state in implementation of article 730 of the Criminal Procedure Law." [216] However, the section of the regulations where the forms are to be found is "reserved."[217] While there is an index of CPL article 730 forms at section 111.8 of the regulations, there are no official forms promulgated to the knowledge of the Task Force.

It is also time to consider anew the benefit of official forms following the decision in *Hirschfeld v. Stone*. [218] In that case, incapacitated defendants confined under article 730 challenged the release of personal information, including HIV status, in fitness reports conveyed to criminal courts. The District Court issued a preliminary injunction, holding that the state's interests in including personal information in reports submitted to courts and used to determine capacity were outweighed by the defendant's privacy interests The *Hirschfeld v. Stone* litigation concluded upon the entry of a consent order endorsed by the District Court, which resulted in the creation of a model competency report However, the model competency report is not uniform because OPWDD was not a party in the *Hirschfeld* litigation. Further, given that outpatient restoration is now legally authorized, examiners should be asked to opine whether the defendant would be a candidate for outpatient restoration. Toward the goal of promoting consistent practices, official forms should be promulgated.

Finally, in 1990, a law was enacted "directing the Law Revision Commission to study provisions of the Criminal Procedure Law and Correction Law to determine their impact [upon people] with mental retardation who are accused of" crimes and to recommend statutory revisions.[219] The study was to take into account the "cognitive ability and adaptive behavior" of persons with mental retardation and was to be conducted in consultation with executive branch agencies, the Mental Hygiene Legal Service, the Commission on Correction, and prosecutor and defense associations, among others. While a bill was never enacted as a result of the Law Revision Commission investigation into these compelling issues, there is no question that over thirty years later, people with

[216] 22 N.Y.C.R.R. 111.8
[217] 22 N.Y.C.R.R. Subtitle D, Chapter I (CPL 730 forms reserved).
[218] 193 F.R.D. 175 (S.D.N.Y. 2000).
[219] Assemb. B. 11695-A, 213 Reg. Sess. (N.Y. 1990) (enacted)

developmental disabilities, including those with autism, continue to encounter significant difficulties and great risk in the criminal justice system.[220]

Reforming CPL 330.20

In New York, the current procedures for the retention, care, and treatment of persons found not responsible by reason of mental disease or defect, were enacted in 1980. The current statute was designed to comply with the constitutional mandates of *Matter of Torsney*[221] and followed a study conducted by the LRC. [222] The detailed statutory scheme, codified at CPL 330.20, was intended to mirror the MHL, but created "new procedures for aspects of post-verdict supervision" applicable only to people charged with a crime who are found not responsible by reason of mental disease or defect. The NYSBA

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[220] *See* Michelle Walton, *Barriers to Justice: Inaccessibility of New York's Criminal Justice System for Individuals with Intellectual Disabilities*. 14 Alb. Gov't L. Rev. 72, 91-92 (2020-2021). The author notes, for example, that in New York, individuals with prison sentences greater than one year are held in the custody of DOCCS. The only screening intellectual disabilities for inmates upon entry into the DOCCS system is a BETA IQ test. Those who score below seventy are referred for full-scale IQ testing and may be referred to the Special Needs Unit ("SNU"). However, individuals with mild or "borderline" intellectual disabilities defined as having an IQ score between seventy and eighty-five, still experience difficulties with adaptive functioning. In 1991, the former Commission on Quality of Care (now the Justice Center for the Protection of People with Special Needs) reported that DOCCS's "battery of academic achievement tests and the Revised Beta IQ test administered to all incoming prison inmates at the reception centers appears to be unreliable in identifying inmates who may be developmentally disabled." A 2016 report by Disability Rights New York found that DOCCS is still not incorporating adaptive functioning assessments into its screening processes for people with developmental disabilities. DOCCS' overreliance on solely IQ testing is concerning because individuals with IQ scores over seventy who have adaptive functioning deficits are not being identified as having a disability, and thus receive no disability-related supports and accommodations.

[221] 47 N.Y.2d 667,674-675 (1979). In *Torsney,* Court of Appeals held that, because insanity acquittees lack criminal culpability, "[b]eyond automatic commitment ... for a reasonable period to determine [acquittees'] present sanity, justification for distinctions in treatment between persons involuntarily committed under the Mental Hygiene Law and persons committed under CPL § 330.20 draws impermissibly thin."

[222] As explained in *Matter of Martin B.,* 138 Misc. 2d 685, CPL 330.20 was a major part of the Insanity Defense Reform Act of 1980. L.1980, c. 548. That Act, in turn, was recommended by the New York Law Revision Commission in a Report prepared in response to a specific request of Governor Carey. Session Laws of New York, 1981, pp. 2251–2293; see also Memorandum on Approving L.1980, c. 548, Session Laws of New York, 1980, p. 1879–1880 and Report of the Law Revision Commission of the State of New York, 1980 at Session Laws of New York, 1980, pp. 1599.

Committee on Mandated Representation issued a report on November 18, 2018, examining the use and efficacy of the Insanity Defense and CPL 330.[223] This Task Force does not repeat that work in its endeavors, but does see value in raising again for public consideration that the insanity defense is rarely invoked and even more rarely successful, while the numbers of people who are incarcerated and have serious mental illness is shockingly high.[224] People charged with a crime who successfully raise the insanity defense statistically will be confined in psychiatric hospitals for significantly longer periods of time than civil patients, despite the evidence showing that longer confinement is not correlated with reduced rates of recidivism.[225] In short, once person has been acquitted based upon on insanity and thereby adjudged to lack criminal culpability, she faces indefinite detention that can exceed the maximum time for which she could have been imprisoned. As the Committee on Mandated Representation commented in 2018, it is little wonder that the defense is so rarely invoked. New York's system for the retention, care, and treatment of those found not responsible by reason of mental disease or defect appears entrenched. However, the statute is over 40 years old and worthy of study and re-examination to ensure that it meets its dual objectives of promoting public safety while meeting the treatment needs of people subject to its provisions.

Recommendations

- Support courts and communities in the use the Sequential Intercept Model to map resources, opportunities and gaps, and develop plans to improve

[223] Report to the Executive Committee of the New York State Bar Association on the Use and Efficacy of Penal Law 40.15 and Criminal Procedure Law 330.20 and Recommendation to Establish a Mental Health Task Force or Committee (2018) (Robert Dean, Chair). Excerpts of the report were later published in an article written by Task Force Members Sheila E. Shea and Christopher Liberati-Conant, '*You Have to Be Crazy to Plead Insanity, How an Acquittal Can Lead to a Lifetime of Confinement*, 91-May N.Y. St. B. J. 28 (2019).

[224] *See,* Shea & Liberati-Conant at p. 31. New York State does not track how often the defense is invoked, but data secured informally be the authors indicates that over the five-year period from 2013-2017, only 11 defendants, out of 19,041 felony and misdemeanor trials statewide, were found not responsible by reason of mental disease or defect after a trial. During the same five-year period, 241 defendants entered a plea of not responsible, compared to 1,375,096 convictions for felonies and misdemeanors. According to OMH, as of June 30, 2018, 260 CPL 330.20 respondents were in secure confinement and 452 were in the community subject to orders of conditions. Meanwhile, as of 2016, approximately 20 % of the people serving sentences in New York State prisons had mental health diagnoses that required OMH services.

[225] Miraglia & Hall, *supra* note 108 at p. 526.

court and community responses to individuals with mental illness, addiction, developmental disabilities, and co-occurring conditions.

- Advocate for funding and resources needed to implement a continuum of diversion programs, treatment and related services to improve public safety as a more humane and cost-effective approach when individuals with mental illness, addiction, developmental disabilities, and co-occurring conditions interface with the criminal legal system.
- Adequately fund beds in both the OMH and OPWDD systems for inpatient restoration for people in the criminal justice system determined to be incapacitated, while requiring OMH and OPWDD to expand and promote the clinical infrastructure required to permit outpatient restoration whenever possible.
- Those people admitted to the hospital or a developmental center for restoration must receive full and co-occurring competent care. [226]
- Recommend CPL article 730 amendment to remove statutory requirement that the prosecution consent to outpatient restoration, while providing prosecutor with notice and an opportunity to be heard before an outpatient restoration order is issued.
- Promote the development and utilization of community-based alternatives to CPL article 730, including Respite and Crisis Respite, Crisis Services and community-based restoration.
- Require OCA to promulgate forms to implement article 730 so that consistent practices are promoted throughout New York State.[227]
- Study and re-examine CPL 330.20 to ensure that it meets its dual objectives of promoting public safety while meeting the treatment needs of people subject to its provisions.
- Official forms to implement CPL article 330 should be updated to reflect that commitments can be to either the custody of OMH or OPWDD.[228]
- Foster and support efforts to ensure that diversion and problem-solving courts are linked to service systems that competently, effectively and

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226 *See*, Glazer testimony, Appendix Document 1.

227 Title 22 New York Code Rules and Regulations, Judiciary, Subtitle D (Ch 1)

228 Title 22 New York Code Rules and Regulations, Judiciary, Subtitle D (Ch II)

efficiently serve participants, allowing for better outcomes and the fullest possible application of justice.

- Consistent with the recommendation made in the *State Courts Leading Change* report, explore, foster and support efforts to deflect and divert people with mental disabilities from the criminal legal system prior to or immediately after arrest.
- Commit to full implementation of Humane Alternatives to Long-Term ("HALT") Solitary Confinement Act and resist efforts to rollback these reforms that are critical to the human and effective treatment of people with mental disabilities who are incarcerated.

E. *Civil Justice*

Legal capacity is a human right which persons with disabilities have the right to enjoy "on an equal basis with others in all aspects of life," and persons with disabilities should be provided with "the support they may require in exercising their legal capacity."[229]

The Task Force membership includes attorneys who practice and have expertise in family law, protection and advocacy systems, guardianship, mental hygiene legal service, and in county and state government. The Task Force recommends reforms of civil justice systems that promote the autonomy and assist people with mental disabilities in exercising their legal capacity. The narrative that follows discusses the execution of advance directives and supported decision making. The report further makes the case for guardianship reform and examines article 9 of the MHL.[230] Reforms in family court and imposing a right to counsel in ERPO proceedings are also recommended. Finally, this section of the report

[229] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

[230] The reader is referred to an article written by Task Force member Jamie Rosen, with Douglas Stern, published in the March/April 2023 edition of the NYSBA *Journal*, *The Unique Role of the Guardian in Inpatient Psychiatric Care,* that explains the intersection of our state's guardianship and civil commitment statutes and the important role a guardian can play as an advocate for appropriate care and discharge planning. 95-Apr N. Y. St. B. J. 43 (2023).

closes with a call to repeal and replace the "hygiene" from the Mental Hygiene Law to adopt a modern nomenclature that does not stigmatize people with mental disabilities.

Promote Individual Autonomy through Psychiatric Advance Directives

Under New York common law, every individual of adult years and sound mind has a right to determine what shall be done with his own body and to control the course of his medical treatment.[231] Patient autonomy and self-determination are basic tenets of New York law that have been faithfully adhered to by courts and codified in various statutes governing informed consent and health care decision making.[232] The priority of the patient's decision is a firmly ensconced principle in New York State law.[233]

As life-sustaining medical technology advanced through the 20th century, it became clear, however, that there was a need for consistent decision-making procedures for patients who lost decision making capacity.[234] Beginning with California in 1976, all states enacted advance directive statutes of some sort, including either living wills or durable powers of attorney (appointing a surrogate decision maker) or both.[235] In 1990, the federal Patient Self-Determination Act ("PSDA") was enacted to promote the use of written advance directives.[236] The PSDA requires health care facilities receiving federal funds to inform patients of their rights under state law to prepare an advance directive, to inquire and document whether patients have executed a directive, to ensure compliance with state laws by respecting advance directives, and to educate health care providers regarding these legal instruments.[237] The same year the federal PSDA was

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[231] *Schloendorff v. Society of N. Y. Hosp*. 211 N.Y. 125 (1914); *In Re Storar*, 52 N.Y. 2d 363 (1981).

[232] *Rivers v. Katz*, 67 N.Y.2d 485 (1986), 492-493; PHL 2405, 2805-d

[233] PHL § § 2983(5), 2994-c (6).

[234] See, Ronna Blau, Lisa Volpe, Christy Coe & Kathyrn Strodel, *Psychiatric Advance Directives: A New York Perspective,* NYSBA Health Law Journal, Vol. 22, No. 1 (Spring 2017).

[235] *Id., citing*, Jeffrey W. Swanson, PhD, S. Van McCrar Phd, Marvin Swartz MD., Eric B. Elbogen, Phd., and Richard A. Van Dorn, PhD., *Superseding Psychiatric Advance Directives: Ethical and Legal Considerations*, 34 J. Am. Acad. Psychiatry Law 385, 386 (2006).

[236] Codified at 42 U.S.C. § 1395cc(f). Passage followed the United States Supreme Court June 25, 1990 decision in *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 269 (1990). Writing for a divided *Cruzan* Court in a 5-4 opinion, Chief Justice Rehnquist determined, among other things, that the United States Constitution did not forbid Missouri from requiring that there be clear and convincing evidence of an incompetent patient's wishes relative to the withdrawal of life-sustaining treatment.

[237] 42 U.S.C. § 1395cc(f).

enacted, New York amended its Public Health Law ("PHL") to permit a patient with capacity to appoint a health care agent.[238] Codified at article 29-C of the PHL, the health care proxy statute was in derogation of the common law which did not permit a third person to decide to forego life sustaining treatment on behalf of a patient lacking decision-making capacity in the absence of clear and convincing evidence of the patient's prior competent choice.[239] There is no legislation in New York expressly authorizing living wills, but they are recognized under the common law as evidence of the patient's intentions pertaining to the rendition or withholding of treatment.

While legal scrutiny in New York has been afforded primarily to life sustaining treatment cases, a legally authorized surrogate, such as a health care agent, is empowered to make any health care decisions on the principal's behalf that the principal could make. "Health care" is broadly defined under the proxy statute to mean "any treatment, service or procedure to diagnose or treat an individual's physical or mental condition."[240] Courts have long recognized that all patients, including patients with severe mental illness, have the right to participate meaningfully to determine the course of their own treatment, to be free from unnecessary or unwanted medication, and to have their rights of personal autonomy and bodily integrity respected by agents of the state.[241] A person is not deemed incapable of making medical decisions simply by virtue of a psychiatric diagnosis.[242] Nonetheless, a mental illness may render a person temporarily unable to make informed choices regarding his or her care and treatment, at a time when they may be in need of treatment.

Psychiatric advance directives ('PADs') are a means for people with psychiatric conditions to retain choice and control over their own mental health treatment during periods of decisional incapacity.[243] A PAD can consist solely of a person's preferences and instructions regarding treatments to be administered or refused when incapacitated, or it can take the form of a proxy directive by which the person appoints a representative to make health care decisions, or a combination of both.[244] Preparing a psychiatric advance directive can be

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[238] L. 1990, c. 752. The legislation was based upon the consensus recommendations of the Task Force on Life and the Law convened by Governor Mario Cuomo in 1985.
[239] *See, In Re Westchester County Med. Ctr. (O'Connor),* 72 N.Y. 2d 517.
[240] PHL § 2980 (4).
[241] *Rivers v. Katz*, 67 N.Y.2d 485 (1986).
[242] *Id.* at 494.
[243] National Resource Center on Psychiatric Advance Directives, https://nrc-pad.org/
[244] *Id*.

empowering for an individual who has been subject to involuntary commitment and treatment. By thinking through and planning for a possible future mental health crisis, the individual can regain control and temper the worst possibilities. Such plans can designate supporters, describe calming techniques and identify triggers, as well the individual's preferences for hospitals, alternatives to hospitalization, crisis programs, treatments and therapies; and clearly state treatments that the individual would not agree to and the reasons for these choices. People prepare the plans to ideally avoid coercive interventions that they have experienced as traumatic.

The use of psychiatric advance directives has indeed been shown to reduce coercive interventions such as civil commitments and involuntary medications, as well as contacts with law enforcement.[245] It also has been shown to improve shared understanding and alignment with treatment providers[246] as well as follow through with chosen treatments.[247] Facilitation and support for completing a PAD can greatly enhance a person's ability to complete the document.[248] This support can come from clinicians or trained peer specialists.[249]

The Center for Medicare and Medicaid Services ("CMS") endorses the use of the PAD in its hospital survey protocol and its inpatient psychiatric facilities quality reporting standards, recognizing that a PAD is akin to a traditional advance directive for health care and is a critical means for a patient to participate in the development and implementation of his or her plan of care.[250] CMS requires that, as a condition for participation in Medicare and Medicaid, a hospital accord a PAD the same respect and consideration given to a traditional advance directive for physical health care.[251] The Substance Abuse and Mental Health Services

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[245] Jeffrey W. Swanson et al., *Psychiatric Advance Directives and Reduction of Coercive Interventions,* J. Mental Health 255 (2008).

[246] Jeffrey W. Swanson et al., *Facilitated Psychiatric Advance Directives: A Randomized Trial of an Intervention to Foster Advance Treatment Planning Among Persons with Severe Mental Illness,* 163 Am J Psychiatry 1943 (November 2006);

[247] Christine M. Wilder et al., *Medication Preferences and Adherence among Individuals with Severe Mental Illness Who Completed Psychiatric Advance Directives,* 61 Psychiatr. Serv. 380-81 (April 2010).

[248] Michelle M. Easter et al., *Facilitation of Psychiatric Advance Directives by Peers and Clinicians on Assertive Community Treatment Teams,* 68 Psychiatric Services 717 (July 2017).

[249] *Id.*

[250] Center for Medicare & Medicaid Services (CMS), "Inpatient Psychiatric Facility Quality Reporting Manual," Version 7.0, pp.2-3; CMS, State Operations Manual Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Rev. 200, 02-21-20, pp.99-100.

[251] *Id.*

Administration offers information, resources,[252] and the Department of Health and Human Services requires certified community behavioral health clinic staff to educate consumers about PADs, and to develop crisis plans, including PAD's, with consumers.[253]

In New York, for Medicaid recipients who have behavioral health histories, a PAD can be uploaded through the Psychiatric Services and Clinical Knowledge Enhancement System ("PSYCKES") database. The New York State Office of Mental Health reiterates the CMS requirement in regulation for all OMH facilities participating in Medicare and/or Medicaid.[254] providers are to consider health care proxy instructions when developing treatment plans for assisted outpatient treatment.[255]

It is the experience of the Task Force that despite these steps and obligations under federal and state law, hospitals often do not honor psychiatric advance directives as they do other health care proxies and living wills. Individuals who issue instructions about their crisis care but who cannot name a trusted proxy are particularly vulnerable to not having their choices overridden because they have not conformed to the health care proxy law. A Supreme Court decision, citing to *Rivers v. Katz* and New York common law, held in 1991 that a hospital must respect an involuntarily committed patient's refusal of electroconvulsive therapy expressed while she had the capacity to refuse treatment.[256] However, this decision has had little apparent influence in the field. The perception of individuals with psychiatric histories– which is well-founded – is that advance treatment decisions will be ignored.[257] This is a significant barrier, particularly for engaging in a process that can involve revisiting painful experiences of unwanted treatment.

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[252] SAMSHA, A Practical Guide to Psychiatric Advance Directives, https://www.samhsa.gov/resource/ebp/practical-guide-psychiatric-advance-directives

[253] https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

[254] 14 N.Y.C.R.R. 527.7

[255] M.H.L. 9.6 (h)(5)(i)(2)

[256] *Matter of Rosa M.,* 155 Misc.2d 103 (S. Ct. New York Cty 1991).

[257] It is very likely that, pursuant to *Rivers v. Katz*, a provider can override a PAD in an emergency, such as when there is imminent danger to a patient or others in the immediate vicinity. *Rivers v. Katz*, 67 N.Y.2d 485, 495-496 (1986) (referencing the State's police powers and an OMH regulation, 14 N.Y.C.R.R. 27.8(b) which applies to OMH operated or licensed facilities). This may be the case if the individual has refused all treatments considered to be effective. However, a PAD may be equally valuable in emergencies by identifying treatments that have been effective and acceptable to the individual under emergency circumstances.

The Task Force supports efforts to expand the use of PAD's because individual choice is an important aspect of recovery as well as a foundation in New York law. Notably, New York City's newly released mental health plan includes a policy and advocacy priority to "[e]xpand provider education, training and accountability for psychiatric advanced directives, and make sure they are integrated into mental health quality improvement policies and programs," in order to "help improve health, decrease suffering, promote social connection and improve overall well-being for people living with SMI."[258]

When effectively developed, disseminated, and respected, PADs can help avoid repeated traumatizing coercive interventions, such as involuntary psychiatric admissions or restraint and seclusion. PADs should also be considered an available resource, along with other advance directives, as less restrictive alternative to guardianship. The Task Force recommends consideration of developing legislation that require recognition of PADs even without proxies in all settings, to fund peer and provider trainings to facilitate their use, and to establish means of transmission, such as registries and web-based access.

Promote Individual Autonomy through Supported Decision Making

In cases where a person is alleged to be unable to make his or her own decisions, the law has traditionally responded by empowering surrogates, including legal proxies or guardians, to act for or on behalf of the individual. Surrogate decision making regimes have increasingly been scrutinized and criticized, however, for curtailing the rights of people with disabilities to autonomy and self-determination.[259] In 2006, the United Nations Convention on the Rights of Persons with Disabilities ("CRPD") recognized legal capacity as a "human right" which persons with disabilities have the right to enjoy "on an equal basis with others in all aspects of life,"[260] and that persons with disabilities should be provided with "the support they may require in exercising their legal capacity."

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[258] City of New York, *Care, Community, Action: A Mental Health Plan for New York City* (March 2023), care-community-action-mental-health-plan.pdf (nyc.gov)

[259] Emily Largent, Andrew Peterson, *Supported Decision-Making in the United States and Abroad*, 23 J. Health Care L. & Policy 271 (2021).

[260] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

[261]Article 12 of the CRPD is widely recognized as the cornerstone for supported decision making and is regarded by some as a mandate to abolish surrogate decision making regimes.[262]

Supported decision-making ("SDM") is a concept rooted in respect for the decision-maker's dignity, autonomy and right to self-determination. A person makes decisions with the assistance of a trusted person, or network of trusted people or supporters. Supporters assist by helping the person to understand and appreciate the options and the consequences of choices to be made, helping the person to gather information needed to decide, and to evaluate the information according to values or principles that the person feels are important. When necessary, the supporter communicates the decision to others. Essentially, SDM broadens how a person is understood to exercise decision-making, thereby advancing the person's autonomy. In 2016, with a grant from the Developmental Disabilities Planning Council ("DDPC"), Supported Decision Making New York ("SDMNY")[263] was formed as a five-year pilot project to explore the use of SDM in New York for people with developmental disabilities. In 2021, a bill to codify SDM and Supported Decision Making Agreements ("SDMA") was first proposed by OPWDD.[264] On July 26, 2022, MHL article 82 was enacted.[265] New York is now one of fourteen states, plus the District of Columbia, whose laws formalize the elements of supported decision-making agreements, including provisions that protect and enhance the autonomy of the decision-maker.[266] Article 82 will be effective upon promulgation of implementing regulations prescribing a process

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[261] *Id.* Supports will be unique to everyone and may involve "gathering relevant information, explaining that information in simplified language, weighing the pros and cons of a decision, considering the consequences of making--or not making--a particular decision, communicating the decision to third parties, and assisting the person with a disability to implement the decision." Kristin Booth Glen, *What Judges Need To Know About Supported Decision-Making, And Why*, 58 No. 1 Judges' J. 26, 27 (2019).

[262] Largent and Andrew Peterson, *Supported Decision-Making in the United States and Abroad*, *supra,* note 251 at p. 283-284.

[263] SDMNY was originally composed as a "consortium of Hunter College/CUNY; the New York Alliance for Inclusion and Innovation (formerly NYSACRA), a statewide association of provider agencies; and Arc Westchester, a large provider organization." https://sdmny.org/the-sdmny-project/history-and-goals/

[264] *See* A. 8586; S.7107 (2021).

[265] L. 2022, c. 41.

[266] In addition to New York, Alaska, California, Colorado, Delaware, District of Columbia, Illinois, Indiana, Louisiana, Nevada, North Dakota, Rhode Island, Texas, Washington, and Wisconsin each have laws establishing SDM.

for creating SDMA for people with developmental disabilities who receive or are eligible to receive OPWDD services. These agreements must follow a recognized SDM facilitation or education process.[267]

Only supported decision-making agreements of people with developmental disabilities completed in accordance with statute and regulations will be afforded full legal recognition under the statute. However, Article 82 contains two provisions signaling the potential for broader application of this decision-making model. The intent of the Legislature is to:

> "strongly urge relevant state agencies and civil society to research and develop appropriate and effective means of support for older persons with cognitive decline, persons with traumatic brain injuries, and persons with psychosocial disabilities, so that full legislative recognition can also be accorded to the decisions made with supported decision-making agreements by persons with such conditions, based on a consensus about what kinds of support are most effective and how they can best be delivered." [268]

Further, MHL § 81.15 states that "additional regulations related to this article may be promulgated by state agencies whose service populations may benefit from the implementation of supported decision-making."[269] In fact, people with psychiatric disabilities and histories in psychiatric systems very strongly advocated for Article 12, with the goal of curbing forced interventions based upon perceived or actual decision-making impairments.[270] Countries which ratified the U.N. Convention, and are therefore obligated to reduce reliance on guardianship,

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[267] Regarding the effective date of MHL article 82, the chapter amendment provides: "This act shall take effect ninety days from the date that the regulations issued in accordance with section one of this act appear in the New York State Register, or the date such regulations are adopted, whichever is later; and provided that the commissioner of mental hygiene shall notify the legislative bill drafting commission upon the occurrence of the appearance of the regulations in the New York State Register or the date such regulations are adopted, whichever is later, in order that the commission may maintain an accurate and timely effective data base of the official text of laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70–b of the public officers law."

[268] MHL § 82.01 (d).

[269] MHL § 81.15; *see,* Morgan K. Whitlatch and Rebekah Diller, *Supported Decision-Making: Potential and Challenges for Older Persons*, 72 Syracuse Law Rev. 165 (2022).

[270] Tina Minkowitz, *Reparation for Psychiatric Violence: A Call to Justice,* in Mental Health, Legal Capacity and Human Rights (2021).

have developed SDM more widely for people who have psychiatric disabilities, than has the United States.[271] However, in the United States, supported decision-making is naturally found among social networks for people with psychiatric disabilities. Clubhouses are intentional communities of peers who share common purpose and tasks and promote individual development and recovery in a supportive environment of trusting relationships. These are natural environments for supported decision-making to develop from trusting relationships.[272] Texas and California have each developed supported decision-making projects which promote supported decision-making through peer specialists and networks to further development of psychiatric advance directives. Crisis planning, such as Wellness Recovery Action Plans ("WRAP") plans,[273] also often involves identifying supporters and assistance with decision-making when needed. While these projects and networks generally do not rely on formal agreements, the process is just as valuable and important to recovery.

The Task Force recommends amending to Article 81 to explicitly include supporters for decision-making as "available resources" as defined under MHL 81.03(e), when considering the need for and/or scope of guardianship.[274] Informal SDM, as well as formal agreements that may differ from Article 82 should be recognized. The Task Force urges OMH to convene a working group to review supported decision-making processes in New York State, to promote peer

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[271] Countries include Canada, Australia, Sweden, United Kingdom, India, Bulgaria, *See* Mental Health, Legal Capacity and Human Rights (2021).

[272] Joel D. Corcoran, Cindy Hamersma, and Steven Manning, *The Clubhouse Model: A Framework for Naturally Occurring Supported Decision Making,* in Mental Health, Legal Capacity and Human Rights (2021).

[273] WRAP is a recovery-oriented plan to manage psychiatric conditions based on five concepts: hope, education, person responsibility, self-advocacy and support. In 1997, an eight-day peer support retreat led by Mary Ellen Copeland identified strategies to prevent emotional and mental breakdown and maintain positive mental health, including: tools that can be used every day to maintain wellness: words to describe wellness: unexpected things that can be "triggers": early warning sign that things are "off": how to know when things have gotten much worse and what to do; action plans for times that are overwhelming; and what to include in a crisis plan or advance directive. The Copeland Center for Wellness and Recovery is a peer-run nonprofit founded in 2002 to spread and meet the growing demand for WRAP Co-Facilitation workshops, empowering people from diverse communities to use WRAP for their own personal recovery journeys.
https://www.welnessrecoveryactionapplan.com/what-iswrap/the-wrap-story
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[274] Additional recommendations to reform Article 81 appear in the next section.

supports and social environments that are conducive to supported decision-making, and to explore the possibility of a pilot project relating SDM and psychiatric advance directives.[275] The Task Force further urges collaboration between OMH and OPWDD to further the use of SDM for dually-diagnosed individuals, including any necessary reasonable accommodations, and to address the needs of the dually-diagnosed when developing the upcoming OPWDD regulations implementing Article 82.

Guardianship Reform

Article 81 of the MHL

The general guardianship statute in New York is codified at Article 81 of the MHL. The purpose of Article 81 is to satisfy either personal or property management needs of an incapacitated person in a manner tailored to the individual needs of that person, which takes in account the personal wishes, preferences and desires of the person, and which affords the person the greatest amount of independence and self-determination and participation in all the decisions affecting such person's life. Article 81 was the careful product of study and review by the New York State Law Revision Commission. Its procedural and substantive due process safeguards were a vast improvement from the old conservator/committee framework of and have withstood the test of time.

[275] When expanding supported decision-making models reports and evaluations of current models should be considered. For example, an evaluation of the SDMNY pilot commissioned by the Developmental Disabilities Planning Council was completed by the Burton Blatt Institute ("BBI") of Syracuse University in 2022. The BBI report, entitled *Looking Back, Looking Forward: An Evaluation of the Surrogate Decision-Making Project with Recommendations to Increase Knowledge, Use, and Acceptance of Supported Decision Making in New York,* lauds the efforts of New York in enacting an SDM statute, but offers a critical examination of certain provisions of the new article 82 of the MHL. Among other things, the BBI report expresses concern that requiring a facilitation process pursuant to OPWDD regulations for an SDMA agreement to be legally recognized by third parties may actually limit rights in cases where people with developmental disabilities are capable of making their own decisions without facilitation. As SDM is implemented for people with developmental disabilities and considered for expansion to other populations, further study should be undertaken. Refinement of the laws and regulations promoting the laudable purpose of SDM is in the public interest.

That said, Task Force members are aware of frequent inquiries from people adjudicated to need guardians who are dissatisfied with their guardians. The complaints often arise in the metropolitan New York City area and involve community guardian programs, but upstate, inquiries of this nature are received, as well. Under MHL § 81.36, a person subject to guardianship or anyone concerned with his or her welfare can request a hearing on the continued need for guardianship powers[276], and the burden of proof is on the guardian to show by clear and convincing evidence that the incapacitated person is still incapable of making reasoned treatment decisions and the guardian's powers are still necessary.[277] While there is a statutory remedy under MHL to modify or terminate guardianships, it is not practical for a person to invoke the remedy, particularly if that person is indigent and unable to retain counsel. The Task Force concerns are shared by the NYSBA Disability Rights which identified as one of its 14 general principles of guardianship that "a person under guardianship has a right to seek review of the guardianship and restoration of rights. There must be a clear process to initiate restoration that permits the person under guardianship to initiate and obtain access to counsel at public expense."[278]

The Task Force offers two recommendations. First, article 81 court examiners should receive training to restore a matter to the guardianship calendar should the examiner receive an inquiry that a person subject to guardianship seeks to modify or terminate the order of appointment. Practices vary around New York State, but some examiners do not engage in oversight relative to personal needs, only property. Another possible avenue for consideration is the development of a form letter or simplified motion procedure so that a person adjudicated to need a guardian can request the appointment of counsel. Counsel could then investigate the matter, advise their client on whether pursuit of termination or modification of the order is likely to be effective, and represent the person under guardianship should she wish to proceed wish to proceed to a hearing. For those people who cannot afford counsel, an attorney should be assigned under County Law Article 18-B[279] or the Mental Hygiene Legal Service could be appointed where its jurisdiction is implicated. In short, in post-adjudication circumstances, particularly where a person may have consented to the appointment of a guardian and is now dissatisfied with the guardian, there ought to be a path to return to court

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276 *See*, MHL § 81.36 (b), (c); § 81.06(a)(6).

277 MHL § 81.36 (d).

278 *See*, Sheila E. Shea, *Guardianship's Article 17-A: Marooned in Time and in Need of Reform*, 95-Feb N. Y. St. B. J. 26, 30 (2023).

279 *See, Matter of Marie H*, 89 NY 2d 889

with representation by counsel. Thus, in an 81.36 proceeding, the individual seeking termination or modification should be afforded the same procedural protections and right to counsel as in the hearing for appointment of a guardian in the first instance.

Article 17-A of the SCPA

A discrete guardianship statute exists in New York that may be invoked for people alleged to require a guardian by reason of an intellectual or other developmental disability or traumatic brain injury ("TBI"). That statute, codified at Article 17-A of the Surrogate's Court Procedure Act ("SCPA"), is a plenary statute the purpose of which at its inception in 1969 was largely to permit parents to exercise continued control over the affairs of their adult children with disabilities. In essence, the statute rested upon a widely embraced assumption that "mentally retarded" people were perpetual children.

Under New York law, a person with developmental disabilities (or a TBI) can be subject to either guardianship statute, despite the considerable substantive and procedural variations between Article 81 and Article 17-A. An injustice arises, as a result, because a petitioner for guardianship can choose between two statutes and petitioner's choice will determine the due process protections to be afforded to a respondent with developmental disabilities.

Article 17-A is marooned in time and a counterweight to progressive principles that typically emerge in New York State, and which are reflected in the newly enacted MHL Article 82. Last year, the NYSBA Disability Rights Committee issued a report arguing that there is an urgent need to reform Article 17-A.[280] The committee maintained that there are 14 general principles that a guardianship statute for adults with intellectual and developmental disabilities should recognize:

> 1. Neither the alleged developmental disability nor the age of the individual alleged to have a developmental disability should be the sole basis for the appointment of a guardian. Rather, the individual's ability to function in society with available supports should be the focus of the court's inquiry into the need for a guardian.

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[280] Report of Disability Rights Committee, *Guardianship for People with Developmental Disabilities*: *Examination and Reform of Surrogate's Court Procedure Act Article 17-A is a Constitutional Imperative* (Joe Ranni, Alison Morris, Co-Chairs) (2021) Appendix Document 11

2. The appointment of a guardian must be designed to encourage the development of maximum self-reliance and independence in the individual. The standard for appointment should be that the person is unable to provide for personal needs and/or property management with available supports, and the person cannot adequately understand and appreciate the nature and consequences of such inability.

3. The appointment of a guardian must be necessary and the least restrictive form of intervention available to meet the personal and/or property needs of the individual as determined by a court.

4. A guardianship petition must allege the other available resources for decision-making, if any, that have been considered by the petitioner and the petitioner's opinion as to their sufficiency and appropriateness, or lack thereof. Other resources include, but are not limited to, powers of attorney, health care proxies, trusts, representative and protective payees and supported decision-making.

5. All persons alleged to be in need of the appointment of a guardian are entitled to due process protections including, but not limited to, notice of the proceeding in plain language and right to counsel of their own choosing or the appointment of counsel guaranteed at public expense.[281]

6. A guardian should not be appointed absent a hearing where the person alleged to be in need of a guardian is present. The person's appearance at the hearing may be dispensed with in exceptional circumstances at the court's discretion and in accordance with statutory standards. The person has the right to a jury trial.

7. The need for the guardianship must be established by clear and convincing evidence of the person's functional limitations that impair the person's ability to provide for personal needs; the person's lack of understanding and appreciation of the nature and consequences of his or her

[281] Some courts will appoint a guardian ad litem for the respondent in a 17-A proceeding. The Task Force notes anecdotally that many GALs are not familiar with the needs of people with developmental disabilities and would benefit from training, especially now with changes in the law that will be forthcoming following the enactment of the supported decision making statute. We take this opportunity to comment and recommend that OCA update its guidelines for attorneys accepting guardian ad litem appointments. The guidelines were last revised twenty years ago, in 2003.

functional limitations; the likelihood that the person will suffer harm because of the person's functional limitations and inability to adequately understand and appreciate the nature and consequences of such functional limitations; and necessity of the appointment of a guardian to prevent such harm.

8. The powers of the guardian should be identified in the order/decree issued by the court and tailored to meet the needs of the individual in the least restrictive manner possible. The person subject to guardianship retains any powers not expressly conveyed to the guardian.

9. The individual must be included in all decisions to the maximum extent possible and practicable, in order to encourage autonomy. The guardian should be encouraging the development of maximum self-reliance and independence in the individual.

10. The duties of the guardian should be specified in the order or decree. Among other things, the guardian's duty is to make decisions that give maximum consideration to the individual's preferences, wishes, desires, and functioning level. A guardian should protect the individual from unreasonable risks of harm, while supporting and encouraging the individual to achieve maximum autonomy.

11. The duration of a guardianship should be determined by the court and conform to the proof adduced at the hearing. For instance, time limited guardianships may be appropriate including where a guardianship is sought for a young adult between the ages of 18 and 25. Where a guardianship of limited duration has been ordered by the court, any application to extend the guardianship should require proof by clear and convincing evidence by the petitioner that it is necessary to continue the guardianship.

12. A person under guardianship has a right to seek review of the guardianship and restoration of rights. There must be a clear process to initiate restoration that permits the person under guardianship to initiate and obtain access to counsel at public expense.

13. The court should retain jurisdiction over the guardianship and entertain modification and termination proceedings where the burden of proof shall be on the person objecting to discharge or seeking increased powers for the guardian rather than on the respondent.

14. The person or entity appointed guardian must be subject to monitoring and oversight by the court. For instance, guardians should periodically file reports as to their activities.

The 14 principles enunciated above are contained within the article 81 guardianship statute. Article 17-A, in contrast, is devoid of most of these essential and fundamental due process safeguards.

While SCPA Article 17-A cries out for reform, it remains a surrogate decision-making remedy in New York State. As stated in the Practice Commentaries to the article, the statute is revered by parents who often commence guardianship applications without the assistance of counsel and at less expense than a typical Article 81 proceeding. [282]Also, many 17-A proceedings are not challenged, causing some to argue that the relative ease in proceeding be retained. Nonetheless, even where a guardianship proceeding is not contested, the relief granted by the court should be informed by the functional abilities of the respondent and constitute the least restrictive form of intervention. Recently reported cases where SCPA article 17-A guardianships were terminated reveal that the plenary nature of the 17-A adjudication is often not consistent with the lived experience of people with developmental disabilities.[283] With the enactment of MHL Article 82, New York now has both supported and surrogate decision-making models for a discrete population: people with developmental disabilities. SCPA Article 17-A and MHL Article 82 stand in stark contrast to one another. Article 17-A results in a plenary adjudication of the need for a guardian with a complete loss of civil rights. Article 82, by comparison, recognizes that "a person's right to make their own decisions is critical to their autonomy and self-determination" and that people with developmental disabilities "are often denied that right because of stigma and outdated beliefs about their capability." [284]

Given the passage of MHL Article 82, the Task Force concludes that it is time to amend and modernize SCPA Article 17-A. The Task Force recommends that the Article 17-A guardianship statute should provide that, where supported decision-making can meet the individual's needs, guardianship is to be avoided as

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[282] *See* Margaret Valentine Turano, Practice Commentaries, McKinney's Cons. Laws of N.Y. SCPA 1750: "Admittedly, the Article 17-A guardianship is not for every disabled person ... On the other hand, the Article 17-A guardianship gives modest families access to affordable judicial process."

[283] *See In re Richard S.H.,* 2022 N.Y. Slip. Op. 22328 (Surr. Ct., Westchester Co. Oct. 26, 2022). The respondent in this case attended college and graduate school and aspired to a career as a social worker to assist children with autism.

[284] MHL § 82.01.

unnecessary. Further, because Article 17-A guardianship remains an available remedy in New York, guardians should be informed of supported decision-making and be guided by its principles. Finally, Article 17-A must be reformed to ensure that the constitutional rights of people subject to the statute are protected. This would include clarifying the rights of people who are currently subject to the statute to seek modification or termination of the guardianship with the burden of proof being on the guardian to demonstrate the need for the guardianship to continue. People who wish to pursue modification or termination of 17-A guardianships should be afforded access to their court files and the right to counsel. The Task Force also recommends that OCA provide forms and instructions on its website addressing the right of a person to seek restoration of their rights. Currently, the OCA website only has forms which assist a person seeking to petition for guardianship, while offering no alternative information for people already subject to the statute who desire to modify or terminate a guardianship.

Promote Single Transaction Remedies

An underutilized provision of New York's adult guardianship law, MHL § 81.16(b), permits a judge to "authorize a [necessary] transaction or transactions" that can solve a single problem or a series of interrelated problems that stem from a health concern. Informally known as a "*one-shot*" provision, section 81.16(b) can, for example, meet a health care provider's need for informed consent to a medical procedure. Using section 81.16(b) thus avoids the imposition of guardianship, permits a person to retain all their rights, personhood, and dignity, while offering a solution to the vulnerable person's immediate health concerns and, importantly, takes into consideration that individual's specific, related challenges. In addition to decisions that are directly related to a person's health and medical treatment, a single transaction solution can also encompass related issues that impact on a person's health, such as preserving that person's home from foreclosure, or securing an inheritance and that makes it possible to pay for necessities. For clients served in the OMH and OPWDD systems, single transaction dispositions have been used very effectively to establish special needs trusts, in those instances where the person may have received an inheritance or a retroactive SSA benefit. The Task Force recommends that OCA encourage through education of the Bench and Bar the single transaction disposition, where appropriate, to avoid unnecessary guardianships.

Article 9 of the Mental Hygiene Law

Removal from the Community and Admission to Psychiatric Hospitals

The principal statute governing inpatient psychiatric hospitalization in New York State is article 9 of the MHL. In 2019, there were over 120,830 legal status admissions to hospitals in New York State.[285] It is well recognized that involuntary civil commitment constitutes a "massive curtailment of liberty," which is constitutionally permissible only if stringent substantive and procedural due process standards are met.[286] Even the "willing patients" (voluntary and informal in New York) are not immune from such loss of liberty, as there is always the potential for these individuals to be converted to an involuntary legal status (e.g., by improperly classifying as voluntary those patients who are unable to understand or exercise their rights or by applying to the court for involuntary retention). They, too, are entitled to constitutional protections.[287]

In general, New York subscribes to a medical model for inpatient admission rather than a strictly legal or judicial model. Voluntary patients must be suitable and willing to be admitted to the hospital.[288] Involuntary admission for a period of up to 60 days is accomplished solely on the certifications of examining physicians, without mandatory judicial review.[289] During this initial admission period, judicial review is elective, and a challenge to involuntary hospitalization must be affirmatively exercised by the patient or others.[290] Mandatory and periodic judicial review applies to admissions that exceed 60 days.[291]

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[285] As reported to the Mental Hygiene Legal Service in accordance with MHL § 9.11. There are parallel provisions codified at Article 15 of the MHL governing admissions to developmental centers in New York State. There are only two developmental centers currently operating in our state which receive people with developmental disabilities on legal status.

[286] *Humphrey v. Cady*, 405 U.S. 504 (1972).

[287] *In re Buttonow*, 23 N.Y.2d 385 (1968).

[288] MHL § 9.13. MHL § 9.17 provides that In order for a person to be suitable for admission to a hospital as a voluntary or informal patient, or for conversion to such status he must be notified of and have the ability to understand the following: 1. that the hospital to which he is requesting admission is a hospital for the mentally ill. 2. that he is making an application for admission.3. the nature of the voluntary or informal status, as the case may be and the provisions governing release or conversion to involuntary status.

[289] MHL § 9.27, 9.37.

[290] MHL § 9.31.

[291] MHL § 9.33.

Article 9 sets forth the legal requirements for civil admissions to a hospital. The statutory scheme, in effect since 1965, establishes a two-tiered or two-stage process for admission and retention of patients in hospitals. The first stage employs the medical model, allowing up to 60 days' confinement without mandatory judicial review. For patients in need of continued involuntary inpatient hospitalization beyond 60 days, the second stage provides for periodic court orders of retention. It has been argued that the medical model is constitutionally impermissible, or at least suspect; and indeed, most states do afford every involuntary patient a probable-cause hearing within five to 15 days of admission. However, both the New York Court of Appeals and the United States Court of Appeals for the Second Circuit have held that New York's statutory scheme is constitutional due to its substantial procedural due process protections, including the availability of the Mental Hygiene Legal Service (hereinafter "MHLS"). [292]

There are several means of involuntary admission under New York's medical model. These sections of the MHL are procedurally and substantively intricate.[293] To the extent that such stringent, detailed requirements make involuntary admission less than easy, they reflect the gravity of the liberty interests at stake. Full compliance with statutory requirements is expected.[294] The Task Force does not endeavor to explain the entirety of the procedural and substantive requirements to sustain civil admissions in New York State and refers the reader to other resources for that purpose.[295] However, during the period of the Task Force's investigation, there was heightened attention to the processes that are used to remove people from the community and transport them to hospitals for psychiatric evaluation and potential admission. Thus, this Report addresses the standards for emergency admission (Section 9.39 of the MHL) and the statutory provisions that permit a

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[292] *See*, *Project Release v. Prevost*, 551 F. Supp. 1298 (E.D.N.Y. 1982), *aff'd*, 722 F.2d 960 (2d Cir. 1983); *Fhagen v. Miller*, 29 N.Y.2d 348 (1972). The MHLS (formerly the Mental Health Information Service), operates pursuant to Article 47 of the MHL and is an auxiliary agency of the Appellate Divisions. The Service has several functions which are defined by statute and uniform regulations of the Appellate Divisions. These duties include, among other things, to study and review the admission and retention of all patients, and to provide legal counsel for its clients in judicial proceedings concerning admission, retention, transfer, care and treatment.

[293] *See Project Release v. Prevost*, *supra* note 373.

[294] *See DeLia v. Munsey*, 26 N.Y.3d 124 (2015).

[295] *See Rights in Facilities,* included in New York State Bar Association publication Representing People with Disabilities, available online at _MHLS Articles (nycourts.gov)

person to be removed from the community for transport and evaluation for admission.

Emergency Admission for Immediate Observation, Care and Treatment

For a period of up to 15 days, a hospital approved by OMH may admit any person who, upon the examination of a staff physician, is alleged to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate, and which likely would result in serious harm to that person or others.[296] "Likelihood to result in serious harm" is defined as:

> a substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself; or
>
> 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.[297]

While the emergency admission is valid for 15 days, the patient may not be retained for more than 48 hours, unless a staff psychiatrist confirms the need for hospitalization.[298] At any time after admission, the patient, a relative or friend, or the MHLS may demand a hearing, which shall be held as soon as practicable, but no more than five days after the court receives the request. The court must determine the matter in accordance with the foregoing standard for admission. Involuntary hospitalization beyond 15 days may be continued by the execution of a two-physician certificate pursuant to Section 9.27 of the MHL.

An additional class of facility called a comprehensive psychiatric emergency program ("CPEP") was created to deal with the large number of patients, particularly in the downstate region, who were held in hospital emergency rooms for extended periods of time while awaiting the availability of regular hospital admission. The first such program began in 1990.[299] Section 9.40 of the MHL provides for the admission of patients who are dangerous to self or others, as defined above. The initial examination must be made within six hours, and it may result in admission for up to 24 hours, with an extension to 72 hours based

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296 MHL § 9.39.

297 MHL § 9.39.

298 *Id*.

299 L. 1989, c. 723

upon a confirming examination by a second physician. Notice and hearing provisions are set forth in Section 9.30 and continued hospitalization is permitted by means of Section 9.39 or 9.27.

Removal Provisions

People may be removed from the community and brought to a 9.39 hospital or CPEP for evaluation and if appropriate, for involuntary admission under section 9.39, by:

- By peace officers and police officers;[300]
- By order of courts of inferior or general jurisdiction; [301]
- By order of the local director of community services; [302]
- By direction of a qualified psychiatrist who is treating or supervising the treatment of the patient at an outpatient mental health clinic or program;[303]
- By the director of a general hospital, as defined in Article 28 of the PHL, that does not have a psychiatric unit;[304]
- By an approved mobile crisis outreach team.[305]

The common standard for all removals is that the person: "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 person may be transported to a 9.39 hospital or a CPEP. In addition, a 2021 chapter amendment to Section 9.41 provides that

> "a person otherwise determined to meet the criteria for an emergency assessment pursuant to this section may voluntarily agree to be transported to a crisis stabilization center under section 36.01 … for care and treatment and, in accordance with this article, an assessment by the crisis stabilization center determines that they are able to meet the service needs of the person."[306]

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300 MHL § 9.41.

301 MHL § 9.43.

302 MHL § 9.45.

303 MHL § 9.57.

304 MHL § 9.57.

305 MHL § 9.58.

306 L.2021, c. 57, pt. AA, § 4, eff. Oct. 1, 2021. A crisis stabilization center shall serve as a voluntary and urgent service provider for persons at risk of a mental health or substance abuse

On February 18, 2022, OMH Commissioner Ann Marie T. Sullivan and Chief Medical Officer Thomas Smith issued interpretive guidance which set forth the circumstances under which courts have determined that the MHL "permits persons who appear to be mentally ill and who display an inability to meet basic living needs" to be mandated into emergency psychiatric assessments and emergency and involuntary inpatient psychiatric admissions.[307] This document was issued by OMH in connection with New York State Governor Kathy Hochul's and New York City Mayor Eric Adams' release of a joint plan to remove people from the New York City subway system.[308] The OMH guidance document does not reference the standards that require probable cause and danger to self or others that underpin a mental hygiene "arrest" under Section 9.41.[309] However, the OMH guidance does specify that for purposes of a Section 9.41 removal, the refusal or inability of a person to meet his or her essential needs for food, shelter, clothing or health care must be immediate; that is, the refusal or inability is likely to result in serious harm if there is no immediate hospitalization.[310]

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crisis or who are experiencing a crisis related to a psychiatric and/or substance use disorder that are in need of crisis stabilization services. Each crisis stabilization center shall provide or contract to provide person centered and patient driven crisis stabilization services for mental health or substance use twenty-four hours per day, seven days per week, including but not limited to: (i) Engagement, triage and assessment; (ii) Continuous observation; (iii) Mild to moderate detoxification; (iv) Sobering services; (v) Therapeutic interventions; (vi) Discharge and after care planning;(vii) Telemedicine; (viii) Peer support services; and (ix) Medication assisted treatment.

307 *See,* Interpretive Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions available online at: https://omh.ny.gov/omhweb/guidance/interpretive-guidance-involuntary-emergency-admissions.pdf

308 *See,* Subway Safety Plan online at: https://www1.nyc.gov/assets/home/dowloads/pef/press-releases/2022.the-subway-safety-plan.pdf.

309 *See, Anthony v. City of New York,* 339 F. 3d 129 (2d Cir. 2003).

310 https://omh.ny.gov/omhweb/guidance/interpretive-guidance-involuntary-emergency-admissions.pdf

On November 29, 2022, Mayor Adams delivered an "Address on the Mental Health Crisis in New York City".[311] Referred to by some as the "NYC Removal Directive," New York City sought to provide guidance to police officers who may be called upon to decide whether a person should be transported to a hospital for evaluation. The announcement prompted objections by, among others, the Association of the Bar of the City of New York.[312] The City Bar maintained that the NYC Removal Directive was vague and raised significant legal issues to ensure the City's compliance with City, State, and Federal anti-discrimination laws, as well as State laws governing mental health treatment and the United States Constitution. The City Bar testimony quoted reports that the police effectuated more than 1,000 removals under Sections 9.41 and 9.58 of the MHL in 2022 before the Removal Directive was issued. The City Bar testimony also concludes that the OMH guidance aligns with case law interpreting Section 9.41 arrests with respect to both the probable cause standard and the requirement of an inability to meet basic needs such that a person represents a present risk of harm to self. The NYC Removal Directive provides examples of reasonable indicia that could result in a removal to include – serious untreated physical injury, unawareness or delusional misapprehension of surroundings, or unawareness or delusional misapprehension of physical condition or health. The standards are argued by the City Bar to be vague, broad, undefined and untethered from case law while missing the temporal urgency standard found in the OMH guidance.

The Task Force is persuaded by the City Bar's analysis of existing statutory and case authorities and likewise would recommend adherence to OMH guidance as the proper standard to apply when removal and transport for evaluation and possible involuntary admission to a hospital is under consideration. Our members are also influenced by the urging of advocates that crisis stabilization centers authorized by MHL § 36.01, which are voluntary alternatives to a psychiatric emergency room, remain largely untested in New York State and should be funded and promoted as a matter of policy.

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311 Transcript available online at: https://www.nyc.gov/office-of-the-mayor/news/871-22/transcript-mayor-eric-adams-delivers-address-mental-health-crisis-new-york-city-holds

312 *See,* Association of the Bar of the City of New York, Written Testimony on Mental Health Removals and Mayor Adams Recently Announced Plan. Appendix Document 12

Assisted Outpatient Treatment

On January 3, 1999, Kendra Webdale was pushed to her death before an oncoming subway train in New York City by Andrew Goldstein, a person with a severe mental illness who was untreated. Responding to this tragedy, the Legislature enacted Mental Hygiene Law § 9.60.[313] At that time of its enactment, nearly 40 other states had enacted a system of assisted outpatient treatment, or "AOT," pursuant to which people with mental illness unlikely to survive safely in the community without supervision may be subject to court-ordered mental health treatment. Before a court may issue an order for assisted outpatient treatment, the statute requires that a hearing be held at which several criteria must be established, each by clear and convincing evidence.[314] Significantly, the statute has certain prerequisites limiting its application to people who have a history of lack of compliance with treatment for mental illness that has either (a) at least twice within the last 36 months been a significant factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition, or (b) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition. The court must also find by clear and convincing evidence that the assisted outpatient treatment sought is the least restrictive treatment appropriate and feasible for the respondent.[315] In 2022, one of the prerequisites was amended to permit an AOT application to be filed when an assisted outpatient treatment order has expired within the last six months, and:

> "…since the expiration of the order, the person has experienced a substantial increase in symptoms of mental illness and such symptoms substantially interferes with or limits one or more major life activities as determined by a director of community services who previously was required to coordinate and monitor the care of any individual who was subject to such expired assisted outpatient treatment order. The applicable director of community services or

313 L. 1999, c. 408 "Kendra's Law."

314 *See,* MHL § 9.60 (c).

315 *See,* MHL § 9.60 (j)(2).

> their designee shall arrange for the individual to be evaluated by a physician. If the physician determines court ordered services are clinically necessary and the least restrictive option, the director of community services may initiate a court proceeding."[316]

If the individual subject to assisted outpatient treatment later fails or refuses to comply with treatment as ordered by the court, if efforts to solicit voluntary compliance are made without success, and if in the clinical judgment of a physician, the respondent may be in need of either involuntary admission to a hospital or immediate observation, care and treatment pursuant to standards set forth in the Mental Hygiene Law, then the physician can seek the respondent's temporary removal to a hospital for examination to determine whether hospitalization is required.[317]

Kendra's Law is not permanent and next expires in 2027.[318] The 2005 reauthorization of the AOT statute required an independent evaluation of the implementation and effectiveness of the AOT program in New Your State.[319] Upon issuing the report in 2009, researchers stated that as designed, AOT can be used to prevent relapse or deterioration before hospitalization is needed. However, in nearly three-quarters of all cases, it was used as a discharge planning tool for hospitalized patients. Thus, AOT was largely used as a transition plan to improve the effectiveness of treatment following a hospitalization and as a method to reduce hospital recidivism. Further, most of New York State's experience with AOT originates in the New York City region where approximately, at the time the report was generated, 70% of all AOT cases were found. AOT was systematically implemented citywide in New York City with well-delineated city-wide policies and procedures. In the remainder of the state, AOT was implemented and utilized at the discretion of each county. The researchers noted that in some counties, AOT had been rarely used; in several it had not been used at all. Based on key

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316 L.2022, c. 56, pt. UU, subpt. H, § 2, eff. April 9, 2022.

317 *See,* MHL § 9.60 (n).

318 Expires and deemed repealed June 30, 2027, pursuant to L.1999, c. 408, § 18.

319 Following a competitive request for proposal, the contract was awarded to the Services Effectiveness Research Program in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center with a subcontract to Policy Research Associates, Inc. of Delmar, New York. The evaluation team was led by Principal Investigators Marvin Swartz, M.D., and Jeffrey Swanson, Ph.D., of Duke and Henry Steadman, Ph.D., and Pamela Clark Robbins of PRA. The final report was issued on June 30, 2009.

stakeholder and recipient interviews and on AOT program data, the researchers found considerable variability in how AOT is implemented across the state, but strong uniformity in how it is implemented in New York City.

The Task Force members recognize that any conversation about reform of the mental health system in New York State must include the assisted outpatient treatment statute. The AOT remedy continues to be employed primarily in the New York City area. Data gathered by the Mental Hygiene Legal Service reflects that 4,138 AOT applications were filed in 2019, with the vast majority of cases arising in the First and Second Judicial Departments.[320] Racial disparities persist in the utilization of the statute with 44% of AOT recipients being Black and 32% Latino in New York City.[321] Duke University concluded in 2009, with similar data, that the racial disparities were a function of poverty, lack of insurance, access to private mental health treatment, and history of psychiatric hospitalizations and not racial discrimination.[322] The substantial racial disparities are nonetheless disturbing indicators of continued disparities in resources and disengagement with health care systems. While the legislative response to the mental health crisis has been to seek to expand eligibility criteria as reflected in the 2022 chapter amendment, our observation is that the law, as written, is not an impediment to accessing treatment, but rather, the lack of community resources remains a persistent problem. Indeed, counties in their self-assessments consistently noted that AOT petitions were the priority for scarce resources. [323]Finally, the Task Force heard from advocates who continue to insist that voluntary treatment options, including those with peer bridging, should be funded and enhanced to reduce reliance on more coercive interventions such as AOT. The perception of coercion, also clearly expressed in comments to OMH town halls [324]was also evident in the Duke University surveys. We agree with this observation and certainly find it consistent with the statutory requirement that

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320 Based upon statistics maintained by the Mental Hygiene Legal Service which is served with every Kendra's Law application and appears as counsel for the respondent unless private counsel is retained.

321 *See,* Association of the Bar of the City of New York, testimony, *supra,* note 310 , *citing*, What's Behind the Increased Use of Kendra's Law in New York City? https://www.gothgazette.com/city/11599-increase-kendra's-law-new-york-city

322 Marvin S. Swartz*, et.al*., *New York State Assisted Outpatient Treatment Evaluation*, Duke University School of Medicine (June 30, 2009).

323 https://www.clmhd.org/contact_local_mental_hygiene_departments/

324 OMH, Local Services Plan and Statewide Town Hall Analysis, September 2022. https://my.vimeo.co/v/1j6edpo3-9zg8pjm

least restrictive treatment options appropriate to the needs of the individual must be exhausted before AOT is imposed by court order.

Provide a Right to Counsel for Respondents in CPLR Article 63-a Proceedings

In 2019, New York State enacted its Extreme Risk Protection Order ("ERPO") statute, CPLR Article 63-a, also known as the Red Flag Law. The law allows the court to issue an ERPO where the petitioner establishes, "by clear and convincing evidence, that respondent is likely to engage in conduct that would result in serious harm to himself, herself or others, as defined in paragraph one or two of subdivision (a) of section 9.39 of the mental hygiene law." [325]If granted, an ERPO requires the respondent to surrender any firearm, rifle, or shotgun in their possession, directs the temporary suspension of the respondent's existing firearm license and ineligibility for such a license, and prohibits the respondent from purchasing or possessing such weapons.

The connection between mental illness and the enactment of New York's ERPO law is clear, including the Legislature's decision to incorporate the definition in MHL § 9.39 into Article 63-a. As noted by the NYSBA Task Force on Mass Shootings and Assault weapons:

> "There are various steps that can be taken to prevent individuals suffering from serious mental illness from having access to firearms thereby minimizing the incidence of mass shootings and the devastating injuries and loss of life that occur, as well as the self-inflicted harm that is often a more probable outcome. … [T]he Task Force examines and makes recommendations concerning three issues of fundamental importance to the proper balance of public safety and individual rights in this area. The first is the subject of so-called "red flag" laws or Extreme Risk Protective Order Laws. "[326]

NYSBA's Criminal Justice Section, the Committee on Disability Rights, and the Committee on Mandated Representation have raised several due process concerns regarding the ERPO law, including the failure to provide a right to counsel to respondents who are financially eligible for counsel.[327] On December

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[325] CPLR 6343

[326] Report of the New York State Bar Association Task Force on Mass Shootings and Assault Weapons (2020)

[327] Report of the New York State Bar Association Task Force on Mass Shootings and Assault Weapons (2020)

22, 2022, the Monroe County Supreme Court ruled in *G.W. v. C.S.*,[328] that CPLR Article 63-a is unconstitutional, in part due to the failure to provide a right to counsel, noting that similarly situated respondents in MHL § 9.39 and Article 10 proceedings are entitled to counsel.[329] The Task Force supports amendment of CPLR Article 63-a to provide a right to counsel. This would ensure that those who are alleged to meet the standard in MHL 9.39 have legal representation and are able to raise other due process issues.

Repeal and Replace Mental "Hygiene"

This report led with a note about language, and we reiterate here that language matters. Negative attitudes and beliefs toward people who have a mental health condition are pervasive. [330] The Task Force urges that non-stigmatizing and respectful language be incorporated into our public discourse, written work and in judicial proceedings. Throughout this report we have endeavored to adhere to these principles. All stakeholders in the delivery of essential services and justice would benefit from training on the tenants of procedural justice and the use of person-first language so we can emphasize the person rather than the condition or an illness. Having said that, we are burdened in New York with the Mental "Hygiene" Law. As Task Force Member Chris Liberati-Conant so cogently explained in his 2023 *Journal* article[331] the mental hygiene movement that gave its name to our law was closely associated with eugenics. The term "mental hygiene" is confusing and potentially offensive to anyone who does not know its history, and to who anyone who does, it is an unpleasant reminder of the early 20th century psychiatric establishment that sought to eradicate the individuals to whom it applies. To what might replace the term, if repealed, those who are subject to the law should be heard. To encompass the three autonomous offices and populations served by them, a name change could be as simple as the Department of Mental Hygiene becoming the Department of Mental Health, Developmental Disabilities and Addiction Services and Support. The "Mental Hygiene Law" could become the "Mental Disability Law" because of the

[328] 78 Misc. 3d 289. Another court has followed suit, in Orange County, and declared the statute unconstitutional for lack of due process protections (*see, R.M. v. C.M.*, 2023 N.Y. Slip. Op. 23088).

[329] *Id.*

[330] Mental health: Overcoming the stigma of mental illness - Mayo Clinic

[331] Chris Liberati-Conant, *It's Time to Take 'Hygiene' Out of the Mental Hygiene Law*, 95 - Feb N. Y. St. B. J. 21 (2023).

definition of "mental disability" would encompass all populations served by the "O" agencies. [332]

Recommendations

- Promote autonomy of individuals with mental disabilities through supported decision-making principles.
- Develop legislation that require recognition of Psychiatric Advance Directives ("PAD"s) even without proxies in all settings, to fund peer and provider trainings to facilitate their use, and to establish means of transmission, such as registries and web-based access.
- Amending MHL Article 81 to explicitly include supporters for decision-making as "available resources" as defined under MHL § 81.03(e), when considering the need for and/or scope of guardianship
- Recommend that OMH convene a working group to review supported decision-making processes in New York State, to promote peer supports and social environments that are conducive to supported decision-making (SDM), and to explore the possibility of a pilot project relating SDM and psychiatric advance directives.
- Recommend collaboration between OMH and OPWDD to further the use of SDM for individuals with dual diagnoses, including any necessary reasonable accommodations, and to address the needs of people who are dually diagnosed when developing the upcoming OPWDD regulations implementing MHL Article 82.
- Promote reform of guardianship statutes in New York State and provide procedural pathways for individuals subject to guardianship under both Article 81 of the MHL and Article 17-A of the SCPA to seek modification of existing orders and restoration of rights.
- Promote Single Transaction Orders as a less restrictive intervention than a plenary guardianship.

[332] *See*, MHL § 1.03 (3).

- OCA should include information and forms on its website regarding the process to remove a guardian and the newly enacted SDM statute (MHL Article 82) as a guardianship alternative. [333]

- OCA should update its guidelines for attorneys accepting guardian ad litem appointments. The guidelines were last revised twenty years ago, in 2003.[334]

- Support amendment of the Extreme Risk Protection Order statute, CPLR Article 63-a, to add a right to counsel for respondents.

- Support amendment of the New York State Constitution and related statutes to remove references to "mental hygiene" and adopting a modern nomenclature that does not stigmatize people with mental health conditions and is more reflective of the values of the community.

F. *Accommodations*

On January 25, 2023, the Office of Court Administration Pandemic Practices Working Group issued its final report entitled *New York Courts' Response to the Pandemic: Observations, Perspectives, and Recommendations*.[335] The working group is an initiative of the Commission to Reimagine the future of New York State's Courts. The Task Force takes this opportunity to comment on court accommodations because the people who are the subject of our inquiry are court users and among the most vulnerable people appearing in civil and criminal proceedings. Lawyers with disabilities are also among our Associations' members and sit on the Task Force.

As noted in the introduction to the Pandemic Practices Working Group Report, "the COVID -19 pandemic was arguably the most disruptive event in the history of New York Courts, and it brought significant hardship to many individuals who depend on the court system." [336] The New York Lawyers'

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333 https://ww2.nycourts.gov/forms/surrogates/guardianship.shtml

334 Publications Home Page | NYCOURTS.GOV - Guidelines for Guardian Ad Litem, with Sample Reports and Forms.

335 *New York Courts' Response to the Pandemic: Observations, Perspectives, and Recommendations,* available at: Reports of the Commission to Reimagine the Future of New York's Courts | NYCOURTS.GOV

336 *Id.*

Assistance Group ("NYLAG") studied pandemic practices extensively and observed that COVID is receding, the changes it wrought on our justice system "are not disappearing overnight, or possibly ever. The present juncture offers a valuable opportunity to step back, regroup, and learn from the courts' pandemic-era experience thus far." [337] That particular framing of the issue causes the Task Force to consider virtual hearings and the impact upon people with mental disabilities.

The Task Force agrees with the Pandemic Practices Working Group which found: 1) that virtual proceedings can benefit people with disabilities and other people requiring accommodations and 2) that virtual proceedings may require accommodations in the same manner that in person proceedings can.[338] The Task Force endorses and agrees with the recommendations found at page 49 of the report of the Pandemic Practices Working Group. In particular, the accommodation of establishing a private means, such as a secure web form, for people to request accommodation, has long been advocated by the NYSBA Disability Rights Committee has benefitting not only litigants but attorneys with disabilities. [339]

OCA issued Guidelines for Handling Requests for Disability Accommodations in 2020.[340] These Guidelines made strides to simplify the Court's reasonable accommodation request process, including eliminating unnecessary jargon, designating a central point of contact for all requests, requiring higher-level review before requests can be denied, tracking denials through a written Denial Accommodation Form, and directing the Statewide ADA Coordinator to review all denials within 10 days. However, these changes only apply to accommodation requests that are classified as "administrative requests"

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[337] https://nylag.org>wp-content>uploads>2021>NYLAG_CourtsDuringCovid_WP_FINAL.pdf Access to Justice in Virtual Court Proceedings: Lessons From COVID-19 and Recommendations for New York Courts, New York Legal Assistance Group, August 2021.

[338] Reports of the Commission to Reimagine the Future of New York's Courts | NYCOURTS.GOV p 42.

[339] The court system is currently piloting the online accommodation form in the NYC courts. https://portal.nycourts.gov/ada-wizard/

[340] Appendix Document 13

and not requests classified as "judicial requests." [341] Court users, lawyers, and *pro-se* litigants with disabilities continue to face barriers obtaining reasonable accommodations when the request is classified as a judicial accommodation. Under the Guidelines, judicial accommodations are handled by the individual judge without the involvement of the Statewide ADA Coordinator, a written Denial Accommodation Form, or an ability to seek a timely review of the denial. As highlighted by the Pandemic Practices Working Group Report, many court users, lawyers and pro-se litigants needed the reasonable accommodation of appearing in court remotely. Yet, the accommodation process was not equally applied to each request because each judge was given the discretion to approve or deny the request. Others faced barriers to participation in remote proceedings and required accommodations in other to do so. There was no consistent response to these requests, even when made by the same party for the same accommodation before the same judge.

The Task Force recommends that the court system adopt the following recommendations with respect to disability accommodations:

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[341] Requests that do not have to be decided by a judge or judicial officer will be decided by the Chief Clerk or District Executive, sometimes in consultation with the Statewide ADA Coordinator. These include most requests for what the ADA calls "auxiliary aids and services," such as sign language interpreters, assistive listening devices, or CART (also known as "real-time") reporting for a person who is Deaf or hard of hearing, or copies of documents in large print, Braille, screen readable, or audio formats for a person who is blind or has low vision. The Chief Clerk or District Executive will also decide requests to modify an administrative practice or procedure, such as relocating a proceeding to a physically accessible courtroom or allowing papers to be filed in a physically accessible location for a person with a mobility impairment, or to provide assistance in filling out a form to a person with a manual impairment. A Chief Clerk or District Executive, however, cannot grant any request that involves a judicial balancing of the rights of the parties or the Judge's or judicial officer's inherent power to manage the courtroom and the proceeding. Examples of such requests may include, but are not limited to, requests for: extensions of time or adjournments; changes in the time of day a case will be heard; permission to participate by phone or video; the presence or absence of other persons in the courtroom; and, modifications in the way testimony is to be given. Those types of accommodation requests must be decided by the judge or judicial officer presiding over the case. If all or some part of the request that is made to a Chief Clerk or District Executive involves an accommodation that only a judge or judicial officer has the authority to provide, the Chief Clerk or District Executive will refer the request (or that part of it) to the judge or judicial officer presiding over the case.

- Ensure centralized decision-making to reduce inconsistency throughout the court system.
- Establish an administrative review process for all judicial accommodation denials. [342]
- Documentation for judicial accommodation requests should be the same as required for administrative accommodations.
- Place guidelines for reviewing accommodation requests into the Judge's Desk Book.

The Task Force also endorses a recommendation made by NYLAG in its report which is that "whenever litigants with disabilities struggle with either in-person or virtual proceedings, the court must consider whether a switch to the other format would serve as an appropriate accommodation." [343] The flexibility engendered by the NYLAG suggestion seems quite important as it may not be apparent that a person with a disability is unable to participate fully in a proceeding (whether in-person or hybrid) until the proceeding is commenced and one form or the other is attempted.

IV. CONCLUSION

> *"We need to recognize that we are deep in a crisis of care, made worse by pandemic loss and by the social inequities that have increased during the pandemic. We need to reframe this crisis as more than a medical challenge. It is a social justice issue."* [344]

There is considerable work to be done to ensure equity and fairness in the justice system and the service delivery system for people with mental disabilities. Task Force endeavored to provide meaningful recommendations for reform as explained in this report drawing from diverse perspectives. We focused on civil and criminal justice issues during our inquiry. Our observations and recommendations were placed in the context of a vast service delivery system that many characterize as "broken" while being mindful that solutions must be trauma informed and further justice. During our investigation, we were guided by the fact

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[342] Under the current Guidelines, a person seeking judicial review of a denial must file an appeal with the Appellate Division.

[343] https://nylag.org>wp-content>uploads>2021>NYLAG_CourtsDuringCovid_WP_FINAL.pdf at p. 18

[344] Insel, *supra*, note 6 p. 241.

that too often the voices of family members and individuals with lived experience are left out of conversations about reform. Public responses can suffer as a result. Task Force members are also mindful that ample evidence exists regarding inequities in both the behavioral health system and the courts. There is, for example, over-representation of minority communities in the justice system and a lack of behavioral health providers of color. NYSBA must lead and join with others calling for evidence-based practices that ensure diversity and equity across all programs designed to improve outcomes for people with mental disabilities involved in the civil and criminal justice systems.

April 10, 2023