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***1037 ENDING DISPARITIES AND ACHIEVING JUSTICE FOR INDIVIDUALS WITH MENTAL DISABILITIES**

INTRODUCTION

The intersection of crime and mental disabilities is a topic of intense public scrutiny and concern.¹ It is well known that the widespread closure of psychiatric hospitals led to an increase in the arrest and incarceration of individuals with mental illness.² Nationally, as the number of state hospital beds that remain open “has fallen to its lowest level on record, ... mentally ill individuals inside and outside the criminal justice system” compete for scarce resources in “a bed shell game with life-and-death implications.”³ Against this backdrop, attorneys who practice in New York encounter statutory schemes governing the adjudication and retention of incapacitated defendants and those determined to not be responsible because of “mental disease or defect”⁴ that are confounding even to the most experienced counsel. Acquiring proficiency in this discrete area of law must be coupled with awareness that defendants with mental disabilities invariably ***1038** confront widespread societal prejudices, myths, and stereotypes regarding their circumstances, such as that those who invoke mental status defenses are malingering or inherently dangerous.⁵

“The [American] public’s outrage [in 1981] over a jurisprudential system that could allow a defendant who shot an American President on national television to plead ‘not guilty’ became a ‘river of fury’ after the jury’s verdict was announced.”⁶ The conditional release of John Hinckley from St. Elizabeth’s Hospital on September 10, 2016, thirty-five years after he shot former President Ronald Regan and three others, is a watershed moment that has caused renewed public criticism of the insanity defense.⁷

Criminal defendants with mental disabilities have been “deprived of treatment, discriminated against, [and] mistreated.”⁸ They have also been subjected to over-punishment because of the harms they endure while incarcerated.⁹ The common view that dangerous propensities are associated with mental illness and that future risk can be predicted is not evidence-based.¹⁰

This article will review the nature of mental disabilities and their prevalence in the criminal justice system, and will introduce fundamental concepts regarding the defense of individuals with mental disabilities. New York State statutes governing the retention, care, and treatment of incapacitated defendants and ***1039** those found not guilty by reason of insanity will be explored in depth along with proposals for chapter amendments to this state’s Criminal Procedure Law. Theory and practice are examined together toward the goal of ending disparities in outcomes for individuals with mental disabilities in the criminal justice system. This article’s conclusion is that miscarriages of justice for those with mental disabilities can be avoided by reform of statutory schemes, education of the bench and bar regarding the nature and consequences of mental disabilities, and by embracing concepts of therapeutic justice not yet integrated into our criminal justice system.¹¹

I. THE NATURE OF MENTAL DISABILITIES

Crucial to achieving justice for any person alleged to be mentally disabled and subject to criminal prosecution is an understanding of the distinctions between psychiatric illnesses, developmental disabilities, and neurological injuries or disorders, all of which can impede a person's capacity. The *Diagnostic and Statistical Manual of Mental Disorders* ("DSM"),¹² provides a common nomenclature for identifying categories of mental disorders and their diagnostic criteria. "Because impairments, abilities and disabilities vary widely within diagnostic category[, the] assignment of a particular diagnosis does not imply a specific level of impairment or disability [that may manifest itself in an individual.]"¹³

Further, distinctions between clinical and legal definitions of mental disorders are subtle and warrant examination.¹⁴ For instance, the New York State Mental Hygiene Law defines "mental disability" as: "[M]ental illness, intellectual disability, developmental disability, alcoholism, substance dependence, or chemical dependence."¹⁵ Its clinical corollary would be a "mental *1040 disorder," defined by the DSM as: "[A] syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning."¹⁶ The legal definition of "mental illness" in New York State is: "[A]n affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation."¹⁷ Some mental illnesses are recurring--such as major depressive disorder.¹⁸ But others, including schizophrenia, typically last a lifetime--even with treatment.¹⁹

Mental disorders as defined by the DSM also include developmental disabilities for which an initial diagnosis typically occurs at some point in childhood.²⁰ Several specific conditions that constitute developmental disabilities within the meaning of New York State law include intellectual disability, cerebral palsy, epilepsy, and autism.²¹ In addition, to properly diagnose a developmental disability, the person's condition must originate prior to the age of twenty-two, continue or be expected to continue for indefinitely, and must also present a "substantial handicap" to "such person's ability to function normally in society."²² Finally, mental disorders also include cognitive disorders.²³ These are disorders characterized by serious impairments in memory or cognitive functioning "that are acquired rather than developmental."²⁴ Common symptoms may include disorientation, confusion, speech and language problems, forgetfulness, or memory loss.²⁵

*1041 Personality disorders, in contrast, are not usually "conditions that render defendants incompetent to stand trial" or relieve them of criminal responsibility.²⁶ In some cases, a defendant may have multiple diagnoses, requiring fact finding and clinical opinion as to the disorder or condition primarily contributing to the defendant's incapacity.²⁷ In any particular case, the clinical and legal terminology discussed above requires contextual application to appreciate and understand the potential cause of a person's alleged diminished mental capacity and his or her ability to stand trial or be held criminally responsible for his or her actions.²⁸

II. PREVALENCE OF MENTAL DISABILITIES IN THE CRIMINAL JUSTICE SYSTEM

Forty-four of fifty states surveyed in 2008 reported that there was at least one jail that was holding more mentally ill individuals than the single largest psychiatric hospital in that state.²⁹ This sobering statistic is reflective of a national trend demonstrating that the rate of jail and prison incarceration increased as the rate of psychiatric hospitalization decreased.³⁰ Many severely mentally ill persons who come to the attention of law enforcement receive their inpatient care in jails and prisons, at least in part, because of a dramatic reduction of psychiatric inpatient beds.³¹ The transformation of persons with severe and persistent mental illness from prisoners to patients to prisoners again is a tragedy reflected in the arc of history:

From 1770 to 1820 in the United States, mentally ill persons were routinely confined in prisons and jails. Because this practice was regarded as inhumane and problematic, until 1970, such persons were routinely confined in hospitals. *1042 Since 1970, we have returned to the earlier practice of routinely confining such persons in prisons and jails.

...

In 2012, there were estimated to be 356,268 inmates with severe mental illness in prisons and jails [in the

United States]. There were also approximately 35,000 patients with severe mental illness in state psychiatric hospitals. Thus, the number of mentally ill persons in prisons and jails was 10 times the number remaining in state hospitals.³²

As stated by one author, there were compelling reasons to close the asylums in the United States, but implementing deinstitutionalization in this country turned out to be a disaster.³³ Specifically, “[s]tate governments, previously responsible for covering the costs of mental health care, exploited deinstitutionalization to offload responsibility and cost. ... Deinstitutionalization turned into transinstitutionalization—at first to nursing homes for the older patients,³⁴ then to prisons for the younger ones.”³⁵

A. Sentence-Serving Inmates in New York State

As of January 1, 2016, there were 52,340 inmates in the custody of the Department of Corrections and Community Supervision (“DOCCS”) in New York State and approximately twenty percent (10,249) were on the caseload of the Office of Mental Health (“OMH”); of those, roughly twenty-two percent (2,322) were ***1043** identified as having serious mental illness.³⁶ The prevalence of mental disabilities among women inmates was more than twice as high as men, according to DOCCS.³⁷ Inmates with mental illness may reside in general population, residential mental health treatment units, and intermediate care programs.³⁸ Others may require inpatient care and treatment at the 208-bed Central New York Psychiatric Center.³⁹ DOCCS also operates special needs units for inmates with developmental disabilities.⁴⁰

Once incarcerated, individuals with developmental disabilities are vulnerable to victimization and theft by other inmates, and are more likely to be sexually assaulted or exploited to violate regulations by other inmates.⁴¹ “Because of limited understanding, inmates with intellectual and developmental disabilities may have greater difficulty following rules when incarcerated, resulting in longer sentences and a lower likelihood of parole.”⁴² Similarly, prison has been described as a “toxic environment” for individuals with serious mental illness.⁴³ Studies reveal that individuals with major mental illnesses, as a class, face a substantial likelihood of incurring serious harm while incarcerated and are substantially more likely to suffer serious harms than non-ill prisoners.⁴⁴

***1044** Alarming, a disproportionate number of mentally ill individuals are still exposed to disciplinary confinement in special housing units (“SHU”), also known as solitary confinement.⁴⁵ Uninterrupted cycles of discipline, psychiatric deterioration, crisis care, and further punishment through disciplinary sanctions are often experienced by inmates with serious mental illness in correctional settings.⁴⁶

B. Detainees in Local Jails

There are numerous studies examining the prevalence of mental illness among adults confined in local jails across the United States.⁴⁷ As one example, a 2006 Department of Justice (“DOJ”) survey reflected that “24% of jail inmates, ... reported at least one symptom of [a] psychotic disorder.”⁴⁸ Similarly, the Council of State Governments released estimates on the prevalence of adults with serious mental illnesses in jails.⁴⁹ Among its key findings were that researchers documented serious mental illness in “14.5 percent of the men and 31 percent of the women [in local jails], which taken together, compris[ed] 16.9 percent of those studied.”⁵⁰ These rates were “in excess of three to six times those found in the general population.”⁵¹ According to the Council of State Governments, “[i]f these estimates are applied to the 13 million jail admissions reported in 2007 ... more than 2 million bookings of a person with a serious mental illness occur annually.”⁵²

***1045** For the vast majority of mentally ill people incarcerated in local jails, the experience varies from being “merely negative to ... catastrophic.”⁵³ There has been intense scrutiny of Rikers Island, New York City’s main jail complex.⁵⁴ “In 1997, about 33,000 prisoners, which was about 25% of the total, received mental health treatment in the New York City jails.”⁵⁵ By 2014, the estimate had grown so that thirty-eight percent of the overall jail population in New York City was considered to have a mental illness.⁵⁶ In December 2014, the New York City Mayor’s Task Force on Behavioral Health and the Criminal Justice System’s Action Plan⁵⁷ announced a comprehensive program to, among other things, reduce the number of people with mental illness “needlessly cycling through the criminal justice system.”⁵⁸

While increased resources may improve outcomes for mentally ill inmates at Rikers Island, they are still not protected by the SHU Exclusion Law,⁵⁹ and thus they can be exposed to the harsh conditions of solitary confinement as a disciplinary sanction.⁶⁰ Studies also demonstrate that individuals with intellectual and developmental disabilities are over-represented in jails as well as prisons.⁶¹ This particularly vulnerable population is deserving of special protections.

***1046 C. Adverse Criminal Consequences for Individuals With Mental Disabilities**

As a consequence of being arrested, a person with a mental illness acquires a criminal record.⁶² That record no doubt influences the actions of law enforcement personnel “in subsequent encounters with the individual and reinforce[s] the tendency to choose the criminal justice system over the mental health system.”⁶³ In other words, the person with a mental illness is now “criminalized.”⁶⁴ As succinctly stated by Lamb and Weinberger:

Once severely mentally ill persons are labeled as offenders, the label may determine not only future law enforcement decisions but court dispositions as well. It has been our experience that after such individuals commit a number of petty and/or nonviolent “crimes,” which may well be related to their mental illness, it is not uncommon for the courts to be more influenced by the defendants’ long “criminal” history than by their psychiatric illness, and thus sentence them to jail or state prison. Not only is such a disposition highly inappropriate and harmful to persons with severe mental illness, but the label of criminal is further reinforced.⁶⁵

The people with mental illness who are most likely to be criminalized are those who are resistant to treatment or who have a history of assaultive behavior.⁶⁶ Individuals with intellectual and other developmental disabilities also face multiple risks as a result of their interactions with the criminal justice system.⁶⁷ “Limited understanding of legal terms and processes, combined with difficulties processing information, may result in their giving up rights without understanding the [legal] consequences [of their decisions] and put them at [greater] risk of wrongful conviction.”⁶⁸ Their circumstances are further “complicated by the fact that ... individuals” with intellectual and other developmental disabilities may have “heightened suggestibility ... increasing their risk of confessing to a crime they did not actually commit.”⁶⁹

***1047 III. CRIMINAL PROCEDURE LAW ADMISSION AND RETENTION IN NEW YORK**

While psychiatric hospital and developmental center beds are closing,⁷⁰ those facilities that do remain open are with greater frequency occupied by people referred for admission from the criminal justice system.⁷¹ “This trend also is occurring in New York State ..., with forensic referrals comprising an increasing portion of the state’s civil (nonforensic) psychiatric hospital census.”⁷² Thus, understanding the statutory procedures for the admission and retention of incapacitated defendants found not responsible is crucial to achieving client objectives in any individual case and promoting justice.

A. Article 730 of the Criminal Procedure Law

***“It is to the Court a finding of phantom fitness with no more substance than a bubble on a baby’s wand.”*⁷³**

With this finding, the Kings County Supreme Court in *People v. A.S.* held that the state psychologist had incorrectly assessed A.S. as being “restored to capacity.”⁷⁴ This case demonstrated that representing a mentally disabled defendant presented unique challenges. A.S. was intellectually disabled (i.e., reading at the first grade level),⁷⁵ and was charged with arson at sixteen years of age⁷⁶--yet despite A.S.’s serious disabilities and the opinions of a psychiatric examiner and a psychologist from the Office for People with Developmental Disabilities (“OPWDD”),⁷⁷ the Commissioner insisted on A.S.’s competence and certified him as fit to proceed.⁷⁸

The Kings County Supreme Court held otherwise, perceiving no ***1048** prospect of future competence on behalf of the defendant.⁷⁹

The case of A.S. highlights the challenges associated with representing a defendant [with mental disabilities]. ... [The defendant] had barely achieved a passing score on [a] Standardized Competency Assessment [tool] ... after multiple attempts during his eight[-]year confinement at a secure developmental center. The defendant’s psychiatric examiner[, as well as an OPWDD-employed psychologist,] opined that a trial would cause AS

“debilitating stress.” ... [N]onetheless, the Commissioner persisted in her position that [the defendant] was competent to stand trial. After weighing the conflicting expert testimony, the [c]ourt determined that A.S. was not competent to stand trial, seizing upon [the defendant’s] “fragile, brittle state.” Further, the [c]ourt granted the ... motion [of the defendant] for *Jackson*⁸⁰ relief on the grounds that it was not likely that the defendant would attain capacity in the foreseeable future.⁸¹

Despite the absence of exact national statistics:

The case of A.S. is but one of an estimated 60,000 annually[,] where competency evaluations are ordered in the United States. ... Major mental illness, intellectual disability, or other cognitive limitations are the most frequent causes of adjudicative incompetence.⁸²

Further:

In New York, a defendant who as a result of mental disease of defect lacks capacity to understand the proceedings against him or to assist in his or her own defense cannot be prosecuted for a criminal offense. Founded upon [now historical] common law principles, New York’s statutory scheme governing fitness to proceed can be *1049 traced back to an 1828 statute which provided that “no insane person can be tried, sentenced to any punishment, or punished for any crime or offense while he continues in that state.” Over time, sporadic attention to the laws governing mentally disabled defendants was said to generate “incredible confusion” over two fundamental issues: (1) how to examine the defendant, and (2) what disposition to make of a defendant found unfit to proceed.

The results of this confusion led to egregious consequences in some cases. For instance, upon undertaking law reform in 1968, the Association of the Bar of the City of New York in cooperation with Fordham Law School observed that the former Code of Criminal Procedure made it possible for an uneducated nineteen-year-old defendant accused of committing a burglary in Brooklyn in 1901 to be confined beyond his 83rd birthday in a maximum security institution operated by the [New York State] Department of Corrections without ever being afforded an opportunity to prove his innocence. Characterized as a “forgotten man,” this defendant was denied a speedy trial and periodic judicial review of his condition, and was confined decades longer than even proof of his guilt would have supported in an overcrowded, understaffed state correctional institution.

Many of the deficiencies of the prior Code of Criminal Procedure were cured in 1970 upon the enactment of the Criminal Procedure Law [However,] the process for determining fitness to proceed, as well as the various alternatives available to the court to address the circumstances of an incapacitated defendant, [still] engender confusion to this day.⁸³

As suggested above, “[p]sychiatric examiners should engage in a contextual and functional analysis of the defendant’s abilities when assessing [a] person’s capacity to stand trial.”⁸⁴ A contextual analysis is unique to the particular circumstances of a defendant and the abilities he or she may be expected to demonstrate as a party to the case.⁸⁵ In contrast, a functional analysis will address the defendant’s current knowledge of the court proceedings and his or her ability to assist counsel in providing relevant information, *1050 conducting him or herself appropriately in court, and making rational decisions about his or her defense in consultation with counsel.⁸⁶

Psychiatric examiners may employ clinical assessment tools during a competency evaluation that will vary depending upon the nature of the defendant’s disability.⁸⁷ For example, the MacArthur Competence Assessment Tool-Criminal Adjudication (“MacCAT-CA”) and Competence Assessment for Standing Trial for Defendants with Mental Retardation (“CAST*MR”) are “two commonly used instruments which assess knowledge, understanding, and reasoning pertaining to court proceedings.”⁸⁸

The MacCAT-CA is “a 22-item test that [typically requires] 30 to 45 minutes to administer.”⁸⁹ Futher:

It has three sections: Items 1 through 8 assess the defendant’s understanding ... [of the role] of the defense attorney, elements of the offense [and] pleading guilty[.]. These items include educational components that allow evaluation of a defendant’s ability to grasp basic, orally presented information about legal proceedings. Items 9 through 16 assess the defendant’s reasoning (e.g., concepts such as self-defense, possible provocation, and ability to seek information that informs a choice). Items 17 through 22 address the defendant’s appreciation of his specific circumstances (e.g., his beliefs about the likelihood of being treated fairly and his rationale for these beliefs).⁹⁰

The MacCAT-CA has been validated with three groups of criminal defendants with varying competence levels and mental illness treatment histories.⁹¹ In contrast, the developers of the CAST*MR were of the opinion that “the open-ended questions used in other instruments ... might not properly assess” the capacity of people with intellectual disabilities.⁹² In addition:

The developers also thought that the vocabulary of other *1051 tests might be too advanced for [defendants with intellectual disabilities] and that the emphasis on psychiatric symptoms might not be appropriate for such defendants. The CAST*MR has 50 items divided into three sections and takes 30 to 45 minutes to administer. The majority of questions are multiple choice. The first two sections require a fourth-grade reading level. The first section includes 25 questions assessing basic legal knowledge ([e.g.,] “What does the judge do?”) and the second section uses the same format to assess the defendant’s ability to assist in his or her defense. The last section has 10 items designed to assess the defendant’s account of events surrounding the charges (e.g., “What were you doing that caused you to get arrested?”). A weakness of [the assessment tool] is that ... recognition format of the test may result in overestimation of a defendant’s abilities.

...

As with ... instruments for evaluation of adjudicative [in]competence, the MacCAT-CA [and the CAST*MR are] not supposed to function as ... stand-alone assessment[s] of competency to stand trial. ... [Rather, d]esigners of these instruments intend that they be used in concert with, rather than as a substitute for, a more comprehensive clinical examination.⁹³

“If a defendant is remanded for commitment following a finding that she is an incapacitated person, it is imperative that the defendant be [confined in] the custody of the proper state official.”⁹⁴ In New York, the Commissioner of the OMH and the Commissioner of the OPWDD are authorized to take custody of incapacitated defendants.⁹⁵ Delays in designating facilities to receive defendants determined to lack capacity as inpatients has not been the subject of litigation in New York.⁹⁶ However, in several other jurisdictions, lawsuits alleging “violations of the rights of defendants with mental illness to timely competency restoration have been” commenced.⁹⁷ The ACLU of Pennsylvania recently announced a settlement with *1052 the Pennsylvania Department of Human Services that will bring significant “changes to [the state’s] under-[funded] forensic mental health services.”⁹⁸

1. Section 730.20: Fitness to Proceed: Generally

Dusky v. United States articulated the standard to be applied in determining whether a defendant has the capacity to stand trial is whether the defendant “has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding--and whether [the defendant] has a rational as well as factual understanding of the proceedings against him.”⁹⁹ The American Academy of Psychiatry and the Law made the following observations about the *Dusky* standard:

Adjudicative competence hinges on a defendant’s present mental state, in contrast with other criminal forensic assessments (e.g., assessments of criminal responsibility or of competence to waive *Miranda* rights at the time of arrest), which refer to past mental states. ... The attention of the courts (and, implicitly, the attention of the psychiatrist) is directed to the defendant’s “ability” to consult rationally with an attorney, rather than the defendant’s willingness to consult rationally. The term “reasonable” connotes flexibility in determining competence, while the phrase “rational as well as factual understanding” requires the courts and psychiatrists to

consider broadly how the defendant exercises his cognitive abilities.

Evaluating clinicians are given no guidance concerning what level of capacity justifies a finding of competence. In stating that the defendant must have “sufficient present ability” to work with his attorney, the Court leaves it to the trial court to decide, in a given case, whether a defendant’s abilities suffice for a finding of adjudicative competence.¹⁰⁰

In New York, the mechanics involved in having a defendant examined for the purpose of determining his or her capacity are set forth in ***1053** [Criminal Procedure Law \(“CPL”\) section 730.20](#).¹⁰¹ The order of examination is usually directed to the local (county or city) mental health director who must designate two qualified psychiatric examiners to evaluate the defendant.¹⁰² The statute was amended in 1989 to eliminate the requirement that psychiatrists be designated to examine the defendant.¹⁰³ Thus, examinations may now be conducted by two psychiatrists, two psychologists, or one from each discipline.¹⁰⁴ Further:

[T]he examination may be conducted at the place the defendant is held in custody, [which is typically a local correctional facility,] or at a hospital. If the defendant is not in custody, [the examination] may be conducted on an outpatient basis. Significantly, unless the defendant has been admitted to a hospital, these [psychiatric] examiners ... are either on the staff of, or retained by, the local (county or city) department of mental health.¹⁰⁵

2. Section 730.30: Fitness to Proceed: Order of Examination

A defendant is presumed competent to proceed and is not entitled as a matter of right to have his or her mental capacity determined by examination and hearing. Entitlement to a hearing depends upon the court’s awareness of some basis for questioning the defendant’s capacity. This may appear from [the] defendant’s prior history combined with the circumstances of the crime brought to the attention of the court by counsel; [or] it may be apparent from the defendant’s actions in the courtroom that the court should initiate an inquiry into fitness *sua sponte*. ... The examination procedure may be initiated by any court in which a criminal proceeding is pending and at ***1054** any time from initial arraignment through sentencing.¹⁰⁶

Subdivision 1 provides:

At any time after a defendant is arraigned upon an accusatory instrument other than a felony complaint and before the imposition of sentence, or at any time after a defendant is arraigned upon a felony complaint and before he is held for the action of the grand jury, the court wherein the criminal action is pending must issue an order of examination when it is of the opinion that the defendant may be an incapacitated person.¹⁰⁷

“Subdivisions two, three, and four set forth the rules governing the action of the court after receipt of the examination reports.”¹⁰⁸ However, “[t]he question of whether a defendant is fit to proceed calls for a judicial determination, not a medical one, and the court need not accept the conclusions of the examiners irrespective of whether they unanimously conclude that the defendant is or is not an incapacitated person.”¹⁰⁹

Although the statute is silent regarding the burden and degree of proof,¹¹⁰ “the Court of Appeals has [determined that] the burden should be on the prosecution to prove competency by a preponderance of the evidence.”¹¹¹

Regardless, however, of the court’s discretion to hold a hearing, one is required if the examiners are not unanimous in their opinions or if a hearing is requested by motion of either the defendant or the [District Attorney]. ... When a defendant’s capacity is in question, the burden is on the [People] to establish that the defendant is fit to proceed by a preponderance of the evidence and that the defendant is not eligible for *Jackson* relief.¹¹²

***1055 3. Section 730.40: Fitness to Proceed: Local Criminal Court Accusatory Instrument**

If the examiners are of the opinion that the defendant is incapacitated, the proceeding is founded on a local criminal court accusatory instrument, and the charge is other than a felony, a final order of observation must be issued. If the charge is a felony, then a temporary order of observation is issued, unless the District Attorney consents to a final order being issued. [This s]ubdivision ... prescribes that both the final and the temporary order can require the defendant to remain in the custody of OMH or OPWDD for a period not to exceed 90 days. The statute also requires that the local accusatory instrument be dismissed with prejudice when the court issues a final order of observation. In [those] cases where the court issues a temporary order of observation, the felony complaint remains open for the duration of the order ... [and then] must be dismissed upon certification that the defendant was in the custody of the Commissioner [at the time the] order expired.¹¹³

...

In 1988, the Westchester County Supreme Court struck down the automatic 90-day commitment [authorized by section 730.40 as unconstitutional] in the case of *Ritter v. Surles*. The state [officer defendants] elected not to appeal the order entered in *Ritter* [and i]nstead, ... instituted a policy in [OMH] 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 [Mental Hygiene Law (“MHL”)].¹¹⁴

In contrast, OPWDD did not immediately adopt any published regulations or policies concerning the retention, care, and ***1056** treatment of defendants remanded to the Commissioner’s custody pursuant to [CPL section 730.40](#).¹¹⁵

Currently, the OPWDD Bureau of Institutional and Transitional Services (“BITS”) makes a placement recommendation for the defendant.¹¹⁶ The defendant may be admitted to a developmental center pursuant to article 15 of the MHL,¹¹⁷ or referred for admission to a less restrictive community placement.¹¹⁸ There is no express statutory time period by which the Commissioner must designate a facility for the defendant’s further evaluation.¹¹⁹ Due process considerations would seem to sanction a brief administrative detention of no more than seventy-two hours following the issuance of the final order of observation to determine whether the defendant is in need of civil admission to a hospital or developmental center.¹²⁰ Such considerations are especially acute for those criminal defendants who may have been subject to an examination order conducted as an outpatient, and those who are exposed to a return to criminal confinement following the dismissal of criminal charges and the issuance of a final order of observation.¹²¹

A defendant remanded for evaluation for admission pursuant to [\[section\] 730.40](#) will most likely be received at a state-operated psychiatric hospital. However, a 2008 amendment to article 730 ... permit[s] the admission of the defendant to a private hospital licensed by OMH, provided ***1057** the hospital agrees to receive the defendant. The amendment offers flexibility to the Commissioner in ascertaining the most appropriate treatment setting for the defendant, but most likely the statutory change was driven by the inordinately high cost of maintaining a person in a state-operated psychiatric bed. Whatever the rationale, the amendment furthers the right of the defendant to treatment in the least restrictive environment consistent with public safety and the defendant’s [treatment] needs.

For those defendants who are committed to the custody of the Commissioner of OMH pursuant to article 730, there is a strict regulatory framework governing their care and treatment while under an order of commitment from a criminal court and the regulations apply even [if] the patient[is] convert[ed] to civil status. The[] regulations require, in part, that before clinical discretion is exercised to release, change status, or grant[ing] furloughs to a patient remanded to OMH custody by a criminal court, there must be a review of the decision by the hospital forensic committee.¹²²

For those defendants committed to the custody of OPWDD, similar reviews are conducted, but there are no OPWDD-implementing regulations parallel to those promulgated by OMH.¹²³

4. Section 730.50: Fitness to Proceed: Indictment

Where the indictment charges a felony, a commitment order is issued for a period of up to one year.¹²⁴ “First [orders] and subsequent orders of retention may be issued upon application by the facility director” and following a hearing upon the court’s *1058 motion, or that of the defendant or the Mental Hygiene Legal Service.¹²⁵

An indicted incapacitated defendant may be held in the custody of the Commissioner indefinitely without achieving dismissal of the indictment, ... so long as the aggregate periods of retention prescribed in the temporary order of commitment, the first order of retention, and any subsequent order do not exceed two-thirds of the authorized maximum term of imprisonment for the highest class of felony charged in the indictment.¹²⁶

Nationally, criminal defendants confined for restoration of capacity are typically confined in the most restrictive, maximum secure forensic hospitals operated by the state whether or not they were arrested for violent crimes, pose a significant threat of danger to the community, or are seriously mentally ill.¹²⁷ This is, in fact, the practice in New York State.¹²⁸ There are four secure facilities in New York operated by OMH that receive defendants upon orders of criminal courts for competency restoration: Kirby Forensic Psychiatric Center in New York County, Mid-Hudson Psychiatric Center in Orange County, the Central New York Psychiatric Center in Oneida County, and the Rochester Psychiatric Center in Monroe County.¹²⁹ For defendants committed to the custody of the OPWDD Commissioner, defendants are received at either the Sunmount Developmental Center in Franklin County or the Valley Ridge *1059 Center for Intensive Treatment in Chenango County.¹³⁰

Where a court finds that [the defendant has not made actual progress towards recovering fitness to proceed and] there is no substantial probability a defendant will attain capacity in the foreseeable future, it may afford relief to the defendant in the form of conversion to civil status without dismissal of the indictment. Conversion to civil status [often] has advantages for the defendant in terms of obtaining increased privileges or possible release from the hospital. As a result of the Court of Appeals decision in *People v Lewis*, however, conversion to civil status [can] have adverse consequences for the defendant [because] time in custody on [a] civil status will not count toward the two-thirds maximum and dismissal of the indictment.

Under CPL 730.50[,] an incapacitated defendant may [be] subject[] to either inpatient or outpatient commitment, but outpatient commitment may only be authorized by order of a superior court with the consent of the District Attorney. [Proposed as a budget bill, t]he 2012 amendment to the CPL permitting outpatient commitment was supported by the rationale that only 20% of defendants committed to OMH or OPWDD custody for restoration of capacity are deemed to otherwise be in need of hospitalization.¹³¹

With the 2012 chapter amendment to CPL 730,¹³² New York *1060 joined the majority of other states that allow for outpatient restoration of capacity.¹³³ Outpatient restoration may offer the most promise for individuals with:

[Developmental disabilities,] cognitive disorders[,] or developmental disorders, or major mental illness, 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, and not abusing alcohol or other chemical substances.¹³⁴

In New York, OMH has issued policy guidance on outpatient restoration,¹³⁵ although outpatient restoration remains an underutilized remedy.¹³⁶

5. Section 730.60: Fitness to Proceed: Procedure Following Custody by the Commissioner

This section deals with the incidents of custody following commitment under a CPL article 730 final or temporary order of observation or an order of commitment. For mentally ill defendants, once a local or superior court has issued an order under this article, the OMH Division of Forensic Services or OPWDD BITS committee is responsible for designating a facility to receive the defendant.¹³⁷ To repeat, the statute contains no temporal limitation within which the Commissioner is required to designate a facility to receive a defendant.¹³⁸

The criminal proceeding is suspended while the defendant is ***1061** incapacitated. [Subdivision four of this section provides, however, that notwithstanding the suspension of the criminal action, the defendant may make any motion appropriate to preserve his or her rights[,] which is susceptible of fair determination without his or her personal participation. This would, for instance, include a motion for dismissal of the indictment based upon an error in its procurement or filing. A defendant who has been in custody for two or more years under a commitment order may also move for dismissal of the indictment upon the consent of the District Attorney and upon a finding that dismissal of the indictment is consistent with the ends of justice and continued custody under an order of commitment is not necessary for the protection of the public or the treatment of the defendant.

...

Subdivision six of this section [also contains] notice requirements which provide, in essence, that any person committed to the Commissioner's custody pursuant to any section of article 730 may not be discharged, released on condition or placed on any less restrictive status unless four days' notice (excluding weekends and holidays) is provided to law enforcement officials, including the District Attorney, and any potential victim of an assault or other violent felony.¹³⁹

The statute provides:

Notwithstanding any other provision of law, no person committed to the custody of the Commissioner pursuant to this article, or continuously thereafter retained in such custody, shall be discharged, released on condition or placed in any less secure facility or on any less restrictive status, including, but not limited to vacations, furloughs and temporary passes, unless the Commissioner or his or her designee, which may include the director of an appropriate institution, shall deliver written notice, at least four days, excluding Saturdays, Sundays and holidays, in advance of the change of such committed person's facility or status, or in the case of a person committed pursuant to a final order of observation written notice upon discharge of such committed ***1062** person, to all of the following: (1) The District Attorney of the county from which such person was committed¹⁴⁰

Article 730 does not require that judicial approval be obtained before OMH or OPWDD afford furloughs to an incapacitated defendant in custody pursuant to an order of observation, order of commitment, or order of retention.¹⁴¹ In limited, statutorily prescribed circumstances, however, the District Attorney (among others) is entitled to receive notice that an incapacitated defendant may be afforded furloughs and may, in turn, in certain circumstances, seek a hearing on the appropriateness of the grant of furloughs.¹⁴² In this regard, CPL section 730.60(6)(c) provides:

Whenever a District Attorney has received the notice described in this subdivision, and the defendant is in the custody of the Commissioner pursuant to a final order of observation or an order of commitment, he may apply within three days of receipt of such notice to a superior court, for an order directing a hearing to be held to determine whether such committed person is a danger to himself or others. Such hearing shall be held within ten days following the issuance of such order. Such order may provide that there shall be no further change in the committed person's facility or status until the hearing. Upon a finding that the committed person is a danger to himself or others, the court shall issue an order to the Commissioner authorizing retention of the committed person in the status existing at the time notice was given hereunder, for a specified period, not to exceed six months. The District Attorney and the committed person's attorney shall be entitled to the committed person's clinical records in the Commissioner's custody, upon the issuance of an order directing a hearing to be held.¹⁴³

Subdivision six was added to CPL section 730.60 in 1980 as a public safety measure.¹⁴⁴ However, if defendants are not permitted *1063 integrated community opportunities while confined for purposes of restoration, their overall treatment progress may suffer.¹⁴⁵ Particularly in the case of developmentally disabled individuals committed to the custody of OPWDD, closely supervised trips into the community provide a therapeutic benefit to defendants by enabling them to practice skills and implement strategies designed to avoid the risk of problem behaviors.¹⁴⁶ Restricting developmentally disabled defendants to the facility without the opportunity for community integration opportunities also implicates federal Medicaid regulations,¹⁴⁷ since the inpatient facilities operated by OPWDD participate in the Medicaid program.¹⁴⁸ Federal regulations provide that individuals who reside in developmental centers must be afforded the “opportunity to participate in social, religious, and community group activities.”¹⁴⁹

One of the few reported cases offering a construction of CPL section 730.60 is *People v. Helfman*.¹⁵⁰ In *Helfman*, the defendant’s final order of observation had terminated and he was confined for a period of thirty days from the expiration date of that order pursuant to CPL section 730.70.¹⁵¹ In ruling that the People lacked standing *1064 to request a hearing under CPL section 730.60(6)(c), the Appellate Division, Second Department, held:

CPL 730.60 (subd 6, par [c]) provides that “[whenever] a District Attorney has received the notice described in this subdivision, and the defendant is in the custody of the Commissioner pursuant to a final order of observation or an order of commitment, he may apply within three days of receipt of such notice to a superior court, for an order directing a hearing to be held to determine whether such committed person is a danger to himself or others Such order may provide that there shall be no further change in the committed person’s facility or status until the hearing.” The final order of observation automatically terminated upon expiration of a period of 90 days. Upon termination of such an order, the superintendent of the institution in which the incapacitated defendant is confined may retain him for care and treatment for a period of 30 days from the expiration date, pursuant to CPL 730.70. Alternatively, the incapacitated defendant may be retained in the custody of the Commissioner as a voluntary patient, an informal patient or an involuntary patient pursuant to the Mental Hygiene Law. At the time Creedmoor Psychiatric Center notified the District Attorney of its intent to discharge defendant he was no longer in custody pursuant to a final order of observation. Apparently, defendant, upon termination of the final order of observation, was retained in the Commissioner’s custody pursuant to CPL 730.70. Since defendant was no longer in the Commissioner’s custody pursuant to a final order of observation, by the express terms of CPL 730.60 (subd 6, par [c]) the District Attorney was not entitled to a hearing.¹⁵²

Thus, the statutory predicate for the District Attorney to request a hearing is that the defendant is confined “pursuant to [either] a final order of observation or an order of commitment.”¹⁵³ However, the Queens County Supreme Court recently held otherwise.¹⁵⁴ The constitutionality of CPL section 730.60(6) as applied to final-order defendants was challenged in *Ritter v. Surles*.¹⁵⁵ According to the *1065 court’s decision, the Commissioner may still notify parties of an upcoming release or change in status, but the release may not be delayed for the purpose of notification.¹⁵⁶ The court also held that the District Attorney no longer has criminal jurisdiction over the “final-ordered” defendant since all criminal charges were dismissed.¹⁵⁷

6. Section 730.70: Fitness to Proceed: Procedure Following Termination of Custody by the Commissioner

When a defendant is in the custody of the Commissioner on the expiration date of a final or temporary order of observation or an order of commitment, or on the expiration date of the last order of retention, or on the date an order dismissing an indictment is served upon the Commissioner, the superintendent of the institution in which the defendant is confined may retain him for care and treatment for a period of thirty days from such date.¹⁵⁸

If the director determines that the defendant remains in need of inpatient care and treatment, he may, before the expiration of such thirty-day period, apply for the defendant’s retention as a civil patient pursuant to articles 9 or 15 of the Mental Hygiene Law.¹⁵⁹

IV. THE INSANITY DEFENSE

In contrast to mental capacity, “which is a prerequisite for a defendant to stand trial, insanity is an affirmative defense that may be raised during the trial.”¹⁶⁰ When invoking the insanity defense, a “defendant admits to committing the offense but argues lack of culpability due to his or her mental state at the time” of the crime.¹⁶¹ While the test used to determine “insanity” varies among jurisdictions, there are two dominant approaches.¹⁶² Under the *M’Naghten* rule,¹⁶³ the trier of fact must determine whether the defendant could understand the difference between right and wrong *1066 and, if not, whether this was due to a mental disease or defect.¹⁶⁴ A less restrictive approach requires showing that the defendant lacked sufficient capacity to appreciate the criminality of his acts, or to conform his actions to the requirements of law, due to mental disease or defect.¹⁶⁵ Within each of these general approaches, variations exist among states.¹⁶⁶ The burden of proof also varies, with some states placing the burden on the People to demonstrate that the defendant was sane at the time of the offense and others requiring the defendant to prove insanity at the time of the offense.¹⁶⁷

There are risks associated with the insanity defense.¹⁶⁸ Studies have revealed “that the insanity defense is [invoked] in only 1% of felony cases, and, when raised, it is rarely successful.”¹⁶⁹ While empirical research varies widely, some studies demonstrate that the “defense succeeds in [only] one out of four cases, while others have found a success rate as low as one in a thousand.”¹⁷⁰ The overall low success rate may itself be a deterrent to making the defense, but there are other reasons to avoid it as well. Specifically:

Defendants whose insanity defenses are unsuccessful—which represents the vast majority of those who raise it—receive significantly longer sentences than those who are convicted without having argued insanity. In other words, defendants pay a penalty for arguing insanity and losing.¹⁷¹ Furthermore, in many states, defendants *1067 acquitted based on insanity often experience longer periods of civil commitment than the maximum length of time in prison that a defendant could have served for the crime.¹⁷²

Thus, there are entrenched incentives for defendants to plead guilty even if they have a viable insanity defense.

The insanity defense in New York is codified at [Penal Law section 40.15](#):

In any prosecution for an offense, it is an affirmative defense that when the defendant engaged in the proscribed conduct, he lacked criminal responsibility by reason of mental disease or defect. Such lack of criminal responsibility means that at the time of such conduct, as a result of mental disease or defect, he lacked substantial capacity to know or appreciate either: (1) The nature and consequences of such conduct; or (2) [t]hat such conduct was wrong.¹⁷³

Because the defense of “not responsible by reason of mental disease or defect” is an affirmative defense, a defendant who raises the issue bears the burden of proof under a preponderance of the evidence standard.¹⁷⁴ The defendant must serve notice of his or her intent to present psychiatric evidence before the trial and within thirty days after a plea of not guilty to the indictment.¹⁷⁵ “In the interest of justice and for good cause,” the filing of such a notice may “be made at any ... time prior to the close of ... evidence.”¹⁷⁶ If the defendant provides such notice, he or she must submit to an examination by the People’s psychiatrist.¹⁷⁷ The defendant’s attorney and the District Attorney have a right to observe the examination.¹⁷⁸ If the defendant refuses to cooperate with the District Attorney’s examination, the court may preclude introduction of evidence of mental disease or defect by the defendant’s expert witnesses.¹⁷⁹ Statements made by a defendant during an examination by the prosecution are admissible only as to issues raised by the affirmative defense.¹⁸⁰ Psychiatric evidence can *1068 be presented by a psychologist¹⁸¹ or a clinical social worker.¹⁸² Upon entry of a judgment of “not responsible,” a defendant becomes subject to the post-verdict or plea provisions of [CPL section 330.20](#).¹⁸³

B. The Disposition of Defendants Found Not Responsible by Reason of Mental Disease or Defect

*“[A] seemingly unresolvable paradox.”*¹⁸⁴

The retention, care, treatment, and release of persons found not responsible of crimes after successfully invoking the insanity defense is a complex process “involving the balancing of ... individual liberties and the protection of society.”¹⁸⁵ Critical to understanding New York’s post-verdict procedures is familiarity with the seminal case of *In re Torsney*.¹⁸⁶ In 1976, Robert Torsney, an on-duty New York City police officer shot and killed a black youth and was subsequently indicted for and

charged with second degree murder.¹⁸⁷ Evidence demonstrated that Torsney fired his weapon without provocation or justification at point-blank range.¹⁸⁸ The defendant admitted the killing, but contended that he was not criminally responsible, due to a mental disease or defect diagnosed as psychomotor epilepsy.¹⁸⁹ There was competing expert testimony from both the prosecution and the defense,¹⁹⁰ and the jury returned *1069 a verdict finding Torsney not guilty by reason of insanity.¹⁹¹

Torsney was committed to a secure psychiatric evaluation center after his acquittal and then transferred to a non-secure hospital for diagnosis and treatment.¹⁹² Within four months, the treating physicians found that Torsney was not dangerous and not mentally ill and recommended that he be released.¹⁹³ After a series of reviews by a special release committee, an independent review panel, and the Commissioner of Mental Health, and following an evidentiary hearing that continued for nine days, the trial court ordered Torsney released on the conditions that he not carry a gun, not continue as a police officer, and continue treatment as an out-patient.¹⁹⁴ The Appellate Division, Second Department, reversed the release order, finding that the evidence failed to establish that Torsney was appropriate for conditional release without danger to himself or others.¹⁹⁵ In a split decision, the Court of Appeals reinstated the trial court's conditional release order, concluding that Torsney was no longer suffering from a mental disease or defect and was not a danger to himself or others.¹⁹⁶

The majority and dissent in *Torsney* disagreed as to the proper construction of the CPL, which at the time provided:

If the court is satisfied that the committed person may be discharged or released on condition without danger to himself or others, the court must order his discharge, or his release on such conditions as the court determines to be necessary. If the court is not so satisfied, it must promptly order a hearing to determine whether such person may safely be discharged or released.¹⁹⁷

A plurality of the court determined that to be constitutional, current dangerousness had to be “causally connected to an identifiable mental disease or defect” at risk of transforming the hospital into a penitentiary.¹⁹⁸ The three-judge dissent would have *1070 held the detention of a person committed to a psychiatric facility following an insanity plea permissible until so long as the person proved that he no longer suffered from the symptoms that made him dangerous.¹⁹⁹

The majority held that the “automatic commitment of persons acquitted of crimes by reason of mental disease or defect is constitutionally permissible only for a reasonable period of time--that is, sufficient time to permit an examination and report as to the detainee's sanity.”²⁰⁰ To support continued retention, the Court of Appeals required a finding that the patient was mentally ill and in need of inpatient treatment.²⁰¹ A dangerous propensity, by itself, was not sufficient.²⁰²

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 1980.²⁰³ The current statute was designed to comply with the constitutional mandates of *Torsney* and followed a study conducted by the New York State Law Revision Commission.²⁰⁴ The detailed statutory scheme, codified at CPL section 330.20, was intended to mirror the Mental Hygiene Law, but created “new procedures for aspects of post-verdict supervision” applicable only to defendants found not responsible by reason of mental disease or defect.²⁰⁵

1. Examination Order

Following an insanity verdict or plea, the trial judge must immediately order a psychiatric examination of the defendant, to be followed by an initial hearing to determine the defendant's current mental state.²⁰⁶ The examination usually takes place in a secure facility for a period not exceeding thirty days, subject to extension *1071 upon application by the Commissioner to the court.²⁰⁷ At least two qualified psychiatric examiners must examine the defendant and prepare reports for submission: in the first instance, to the Commissioner, and then to the judge.²⁰⁸

2. The Initial Hearing, Commitment Orders, and Orders of Condition

Within ten days after receipt of the examination reports, the trial judge must conduct an initial hearing.²⁰⁹ The initial hearing is a critical stage of the proceeding because the court will determine “the level of judicial and prosecutorial involvement in future decisions” concerning the defendant's confinement, transfer, and release.²¹⁰ “Based on its findings, [at the initial hearing,] the court then assigns the [defendant] to one of the three tracks.”²¹¹ Track-one defendants are those found by the trial

judge to suffer from a dangerous mental disorder; i.e., a mental illness that makes them “a physical danger to [themselves] or others.”²¹² Track-two defendants are mentally ill, but not dangerous,²¹³ while track-three defendants are neither dangerous nor mentally ill.²¹⁴

“Track status, as determined by the initial commitment order, governs the [defendant’s] level of supervision in future proceedings and may be overturned only on appeal from that order, not by means of a rehearing and review.”²¹⁵ The trial judge must issue a commitment order consigning track-one defendants “to the custody of the Commissioner for confinement in a secure facility for care and treatment for six months.”²¹⁶ Track-two defendants are ordered into *1072 the Commissioner’s custody for detention in a non-secure (civil) facility, subject to an order of conditions.²¹⁷ The order committing a track-two defendant is deemed made pursuant to the Mental Hygiene Law rather than CPL section 330.20; concomitantly, subsequent proceedings regarding retention, conditional release, or discharge of a track-two defendant are generally governed by articles 9 (mentally ill) or 15 (developmentally disabled) of the Mental Hygiene Law.²¹⁸

Track-three defendants are discharged either unconditionally or, in the judge’s discretion, with an order of conditions.²¹⁹ An order of conditions is “an order directing a defendant to comply with [the] prescribed treatment plan, or any other condition which the court determines to be reasonably necessary or appropriate, and, in addition, where a defendant is in custody of the Commissioner, not to leave the facility without authorization.”²²⁰ Such orders are valid for five years and may be extended indefinitely upon a mere finding of “good cause shown.”²²¹

As observed by the Court of Appeals in *Matter of Norman D.*, “track-one status is significantly more restrictive than track-two status.”²²² With a track-one designation, a defendant:

[I]s subject to ongoing supervisory terms of court-issued commitment orders and subsequent retention orders; he ... must be confined to a secure psychiatric facility for an initial period of six months; a court order is required for any transfer to a non-secure facility, off-ground furlough, release or discharge; and the District Attorney’s office continues to be notified of, with the option of participating in, further court proceedings involving [the defendant’s retention, care *1073 and treatment].²²³

The terms “dangerous mental disorder” and “mentally ill” are terms of art under CPL article 330:

(c) “Dangerous mental disorder” means: (i) that a defendant currently suffers from a “mental illness” as that term is defined in subdivision twenty of section 1.03 of the mental hygiene law,²²⁴ and (ii) that because of such condition he currently constitutes a physical danger to himself or others.

...

(d) “Mentally ill” means that a defendant currently suffers from a mental illness for which care and treatment as a patient, in the in-patient services of a psychiatric center under the jurisdiction of the state office of mental health, is essential to such defendant’s welfare and that his judgment is so impaired that he is unable to understand the need for such care and treatment; and, where a defendant is mentally retarded, the term “mentally ill” shall also mean, for purposes of this section, that the defendant is in need of care and treatment as a resident in the in-patient services of a developmental center or other residential facility for the mentally retarded and developmentally disabled under the jurisdiction of the state office of mental retardation and developmental disabilities.²²⁵

In March 1995, the Court of Appeals issued its seminal decision *1074 in *In re George L.*,²²⁶ construing what it means to currently suffer from a “dangerous mental disorder.”²²⁷ George L. was acquitted of attempted murder, assault, and reckless endangerment charges and committed to Mid-Hudson Psychiatric Center.²²⁸ At his initial hearing, three psychiatrists testified, all of them agreeing that he suffered from acute paranoid schizophrenia, which was in remission as long as he took his medication.²²⁹ Two of the doctors opined that George L. did not have a dangerous mental disorder, but was “mentally ill” and could be safely confined in a non-secure hospital.²³⁰ The opinion of the People’s witness as to the defendant’s prognosis was

“considerably less sanguine” and testified that there was a high probability of relapse for people diagnosed with schizophrenia, as was George L.²³¹

The trial court found the defendant to have a dangerous mental disorder even though he was not “specifically dangerous” at the time of the initial hearing, resulting in a track-one disposition.²³² The Appellate Division, Second Department, affirmed.²³³ On George L.’s appeal to the Court of Appeals, the high court declined to adopt the defendant’s construction of the word “current” and instead held that CPL section 330.20 “does not constrain a court to determining dangerousness as of the moment in time” when the hearing is conducted.²³⁴ Borrowing upon its foundational precedent in *Torsney*, the Court of Appeals in *George L.* held that the state was permitted to engage in a presumption that the causative mental illness continues beyond the date of the criminal conduct.²³⁵ Additionally, the court stated:

Of course, a finding that a defendant “currently constitutes a physical danger to himself or others” must be based on more than expert speculation that he or she poses a risk of relapse or reverting to violent behavior once medical treatment and *1075 supervision are discontinued. The prosecution may meet its burden of proving that a defendant poses a current threat to himself or others warranting confinement in a secure environment, for example, by presenting proof of a history of prior relapses into violent behavior, substance abuse or dangerous activities upon release or termination of psychiatric treatment, or upon evidence establishing that continued medication is necessary to control defendant’s violent tendencies and that defendant is likely not to comply with prescribed medication because of a prior history of such noncompliance or because of threats of future noncompliance. Dependence upon factors such as these--clearly evidencing a defendant’s threat to himself or society--is warranted to justify the significant limitations on an insanity acquittee’s liberty interest [that] accompany secure confinement.²³⁶

Thus, the *George L.* decision adopted a presumption that the mental illness that led to the criminal act continues after the plea or verdict of not responsible “and that ... assessments [of dangerousness] should not be limited to a point in time but rather should be contextual and prospective in nature.”²³⁷ Under New York jurisprudence, the presumption of dangerousness continues, in fact, and is not extinguished by a subsequent finding that the defendant no longer suffers from a dangerous mental disorder.²³⁸

3. First and Subsequent Retention Hearings: Retention Orders, Transfer Orders, and Release Orders

At least thirty days before a track-one defendant’s initial six-month commitment period lapses, the Commissioner must apply to the trial judge, or a superior court in the county where the defendant is securely housed, for a first retention order or a release *1076 order.²³⁹ The Commissioner must give written notice of this application to the District Attorney, the defendant, his counsel, and the Mental Hygiene Legal Service.²⁴⁰ Upon receipt of the application, the judge on his own motion may, or upon timely demand by one of those individuals or entities receiving notice must, conduct a hearing.²⁴¹ If the judge finds that the track-one defendant still suffers from a dangerous mental disorder, she must issue a first retention order, authorizing secure confinement for another year, and thereafter (before expiration of the first, second, and any subsequent retention orders, and assuming the defendant’s dangerous mental disorder persists), for succeeding periods of up to two years.²⁴² Alternatively, if the judge finds during a first or subsequent retention proceeding that a track-one defendant is mentally ill but no longer suffers from a dangerous mental disorder, she must issue a retention order along with a transfer order and an order of conditions.²⁴³

In the event that the judge finds that the defendant no longer suffers from “a dangerous mental disorder and is not mentally ill, [he or she] must issue a release order and an order of conditions.”²⁴⁴ A transfer order directs the Commissioner to move the defendant from secure to non-secure confinement.²⁴⁵ A release order “direct[s] the Commissioner to terminate [the] defendant’s in-patient status without [ending his] responsibility for the defendant.”²⁴⁶ When a defendant is in the Commissioner’s custody before expiration of the period prescribed in a first, second, or subsequent retention order, the same procedures govern application for issuance of any subsequent retention order.²⁴⁷

4. Transfer Orders

At any time while the track-one defendant is in the Commissioner’s custody pursuant to a retention or recommitment order,

the Commissioner may apply to the court that issued the order then in effect, or to a superior court in the county where the *1077 defendant is securely housed, for a transfer order if, in his view, the defendant no longer suffers from a dangerous mental disorder, or, “consistent with the public safety and welfare of the community and the defendant, the [defendant’s] clinical condition ... warrants” the lesser level of confinement.²⁴⁸ “The Commissioner must give ten days [’] written notice [of this application] to the District Attorney, the defendant, [his] counsel ... and the Mental Hygiene Legal Service.”²⁴⁹ “Upon receipt of [the] application, the [judge] ... on [his] own motion” may, or upon demand by the District Attorney must, conduct a hearing on the application.²⁵⁰ He must grant the application and issue the transfer order, along with an order of conditions, if he finds that the defendant does not suffer from a dangerous mental disorder, or that the defendant’s transfer from secure to non-secure detention is consistent with the public safety and welfare of the community and the defendant, and is warranted by the defendant’s clinical condition.²⁵¹

If the District Attorney does oppose the transfer, he or she “must establish to the satisfaction of the court that the defendant has a dangerous mental disorder or that the issuance of a transfer order is inconsistent with the public safety and welfare of the community.”²⁵² In *In re Arto ZZ*,²⁵³ the Appellate Division, Third Department, considered the People’s appeal from a transfer order for a defendant with developmental disabilities. The appellate court affirmed the order on the strength of the testimony of the Commissioner’s expert witness, who opined that respondent had made “steady therapeutic progress” and “transfer to a non-secure facility was the appropriate next step in [the defendant’s] treatment.”²⁵⁴ Placing reliance on evidence of past relapses, the District Attorney sought to demonstrate that the defendant was currently dangerous.²⁵⁵ The Third Department rejected this line of reasoning, noting that the defendant’s last relapse had been a decade before the filing of the application for a transfer order and that deference would be afforded to the trial court’s assessment of the expert opinion.²⁵⁶ Individuals who are subject to *1078 CPL section 330.20 are not permitted to initiate applications for transfer to non-secure confinement, or for that matter, for furloughs or release.²⁵⁷

However, a writ of habeas corpus is an available remedy for a person subject to the statute, who seeks to be transferred from secure to non-secure confinement upon the grounds that she no longer suffers from a dangerous mental disorder, but is mentally ill, or for a person who maintains that she is suitable for release.²⁵⁸

As the discussion of the statutory framework for the retention and transfer of track-one defendants reveals, the statute contemplates a “step-down” or staged system of confinement where individuals move from secure to non-secure confinement and ultimately conditional release upon improvement in mental status.²⁵⁹ In *In re David B.*,²⁶⁰ the Court of Appeals addressed the “showing of dangerousness required to retain an insanity acquittee in a non-secure psychiatric facility pursuant to [the] Criminal Procedure Law.”²⁶¹ Interpretation was required, in part, because on its face, the statutory definition of “mentally ill”²⁶² does not include an element of dangerousness and elements of dangerousness are required elements of any commitment or retention of an insanity acquittee.²⁶³ The parties to the proceeding agreed that “there is a constitutionally required minimum level of dangerousness to oneself or others that must be [demonstrated] before an insanity acquittee may be retained in a non-secure facility.”²⁶⁴ The issue for the Court of Appeals was to determine the level of dangerousness that would suffice to permit the state to retain the acquittee in custody and whether the lower courts applied the proper standard.²⁶⁵

Borrowing from its prior precedent in *George L.*, the Court of Appeals held that “dangerousness may be supported by evidence of violence, [but that] dangerousness is not coterminous with violence.”²⁶⁶ Further, the court stated:

*1079 Apart from evidence of violence, [however,] retention of an insanity acquittee in a non-secure facility is justified where the state shows by a preponderance of the evidence that continued care and treatment are essential to the physical or psychological welfare of the individual and that the individual is unable to understand the need for such care and treatment. Retention also may be supported by the need to prepare for a safe and stable transition from non-secure commitment to release. Thus, in addition to recent acts of violence and the risk of harm to the defendant or others that would be occasioned by release from confinement, a court may consider the nature of the conduct that resulted in the initial commitment, the likelihood of relapse or a cure, history of substance or alcohol abuse, the effects of medication, the likelihood that the patient will discontinue medication without supervision, the length of confinement and treatment, the lapse of time since the underlying criminal acts and any other relevant factors that form a part of an insanity acquittee’s psychological profile. While these determinations include many of the same factors we identified as relevant in *George L.*, they need not be as pronounced in the case of retention in a non-secure facility.²⁶⁷

Because the lower courts may have precluded evidence related to dangerousness, the cases of *In re David B.* and *In re Richard S.*²⁶⁸ were remanded to permit findings to be made or, as the trial judge deemed appropriate, to “allow additional relevant evidence” to be introduced.²⁶⁹ In *In re Richard S.*, on remand in 2003, the trial court found that Richard S. was mentally ill and dangerous and required confinement in a non-secure facility.²⁷⁰ The Appellate Division affirmed, concluding that Richard S. “meets all the criteria for retention in a non-secure facility.”²⁷¹ It found that the lower court’s findings of mental illness and dangerousness were supported by a “strong preponderance of the credible evidence,” and that the lower court implicitly concluded that Richard S. was “not cured, [and that] treatment [was] essential for his psychological welfare and the safety of others, and he [was] unable to comprehend the *1080 need for such treatment.”²⁷² It rejected as “without merit” Richard S.’s contention that his continued confinement was improper absent a showing of “volitional impairment” or difficulty controlling his behavior.²⁷³ The Court of Appeals dismissed Richard S.’s appeal of that decision.²⁷⁴

Richard S. then filed a habeas corpus petition in the U.S. District Court for the Northern District of New York challenging, among other things, the state’s failure to apply the Supreme Court’s holding in *Kansas v. Crane*²⁷⁵ to his case.²⁷⁶ In addition, he argued that he had established by clear and convincing evidence that he did not have serious difficulty in controlling his behavior.²⁷⁷ The writ was denied by the District Court, but an appeal ensued to the U.S. Court of Appeals for the Second Circuit.²⁷⁸ As a threshold matter, the Second Circuit disposed of the state’s contention that *Kansas v. Crane* did not govern the due process standards for insanity acquittees.²⁷⁹

The Second Circuit held that *Crane* and *Kansas v. Hendricks*²⁸⁰ “rephrased the general constitutional standard for civil commitment of insanity acquittees and other candidates for civil commitment to clarify that proof of mental illness embrace[d] proof of a mental [disorder] that makes it difficult to control one’s dangerous behavior.”²⁸¹ Further, the Second Circuit determined that there would be “no justification for the contention that the Supreme Court meant this standard to apply only to convicted sex offenders, given the broad coverage of the Kansas Act and the context of the Court’s discussion.”²⁸²

To the extent that Richard S. maintained that *Crane* required a specific finding with respect to lack of control, the Second Circuit did not find support for that proposition in the controlling Supreme *1081 Court precedents.²⁸³ Thus, the rule that emerged from *Richard S. v. Carpinello* was that the Supreme Court neither strayed from nor expanded its core holding that for involuntary commitment to withstand due process scrutiny, a state must prove mental illness and dangerousness.²⁸⁴ “*Hendricks* and *Crane* provided an explanation of the mental illness portion of the test: the state may satisfy this component by proving that an individual has a mental condition, abnormality or disorder that is sufficiently severe that he has serious difficulty in controlling his dangerous behavior.”²⁸⁵ On the record before the Second Circuit, the panel affirmed denial of the writ, concluding that “the state courts did not unreasonably apply clearly established federal law with respect to the involuntary commitment of Richard S., nor did they unreasonably determine the facts with respect to his mental illness and its link to his dangerousness.”²⁸⁶

5. Furlough Orders

Once committed to the custody of the Commissioner under track-one, the Commissioner may apply for an escorted or unescorted furlough order.²⁸⁷ All furloughs are subject to court approval and must be made upon notice to the prosecuting District Attorney.²⁸⁸ The statute provides in pertinent part, as follows:

The Commissioner may apply for a furlough order, pursuant to this subdivision, when a defendant is in his custody pursuant to a commitment order, recommitment order, or retention order and the Commissioner is of the view that, consistent with the public safety and welfare of the community and the defendant, the clinical condition of the defendant warrants a granting of the privileges authorized by a furlough order Upon receipt of such application, the court may, on its own motion, conduct a hearing to *1082 determine whether the application should be granted, and must conduct such hearing if a demand therefor [sic] is made by the District Attorney. If the court finds that the issuance of a furlough order is consistent with the public safety and welfare of the community and the defendant, and that the clinical condition of the defendant warrants a granting of the privileges authorized by a furlough order, the court must grant the application and issue a furlough order containing any terms and conditions that the court deems necessary or appropriate.²⁸⁹

In 2014, the Appellate Division addressed for the first time, in the case of *In re James Q.*,²⁹⁰ the standard of review to be

applied when the Commissioner applies for a furlough order.²⁹¹ The court observed that the “legislature specified that the [District Attorney] has the burden on an initial hearing seeking a commitment order.”²⁹² “If [the Commissioner] seeks to retain a defendant in ... custody, the legislature [likewise] placed the burden on [the Commissioner] to establish the elements necessary for retention.”²⁹³ Further, should the Commissioner seek release of the defendant, and were the People to oppose that relief, “the legislature placed the burden on the [District Attorney] to establish the elements necessary for retention.”²⁹⁴

“Unlike those situations, the legislature did not” expressly proscribe which party “bears the burden on a furlough application.”²⁹⁵ The court reasoned, however, that:

Because the statute does not assign the burden and [the Commissioner] is the only person authorized by the statute to apply for a furlough order, the only logical conclusion is that the legislature intended for [the Commissioner] to bear the burden of proving that a furlough order should be granted.²⁹⁶

Because the Court of Appeals had “determined that the preponderance of the evidence standard applies to [CPL] commitment and retention orders,”²⁹⁷ and “[a]bsent any legislative *1083 indication that a different standard should apply ... [or] any constitutional concerns, [the Third Department held] that [the Commissioner’s] burden on a furlough application is to prove the appropriateness of a furlough order by a fair preponderance of the credible evidence.”²⁹⁸ The Third Department further held that it would “review *de novo* Supreme Court’s determination as to whether to grant a furlough order, but defer to the [trial] court’s determination regarding [the] applicable terms and conditions” of the furlough.²⁹⁹ Explaining its rationale, the court noted that the statute provides that:

[I]f certain requirements are satisfied, “the court must grant the application and issue a furlough order containing any terms and conditions that the court deems necessary or appropriate.” The legislature’s use of the word “must” [according the court,] indicates a lack of discretion, such that an order is mandated upon proof that the statutory conditions are established. If an order is required by the statute, however, the statute provides broad discretion to the [trial] court regarding the inclusion of terms or conditions.³⁰⁰

Thus, provided that the “evidence [establishes] that a furlough order is required” upon appellate review, the court would “only disturb the terms and conditions of that order if [the trial c]ourt abused its discretion in” granting them.³⁰¹ On the merits, the court determined that the Commissioner had met her burden of proof and that several of the People’s concerns about the proposed furloughs were “unrealistic or overly alarmist regarding potential danger to the community,” particularly because the furloughs “were based [upon] a risk management plan that required constant supervision.”³⁰²

6. Conditional Release

At any time while a track-one “defendant is in custody pursuant *1084 to a retention ... or recommitment order,” the Commissioner may apply to the court that issued the order in effect, or to a superior court in the county where the defendant is housed, for a release order if, in the Commissioner’s view, the “defendant no longer [suffers from] a dangerous mental disorder and is no [t] ... mentally ill.”³⁰³ “The Commissioner must give ten days written notice to the District Attorney, the defendant, counsel for the defendant, and the Mental Hygiene Legal Service.”³⁰⁴

Upon receipt of the application, the judge “must promptly [hold] a hearing to determine the defendant’s present mental condition.”³⁰⁵ “If the [judge] finds that the defendant [suffers from] a dangerous mental disorder, [he] must deny the application for a release order[; but if he] finds that the defendant does not [suffer from] a dangerous mental disorder but is mentally ill, [he] must issue a transfer order,” with an order of conditions, assuming the “defendant is [still] confined in a secure facility.”³⁰⁶ But “[i]f the [judge] finds that the defendant does not [suffer from] a dangerous mental disorder and is not mentally ill, [he] must grant the [Commissioner’s] application and issue a release order” with an order of conditions.³⁰⁷ Further:

The order of conditions issued in conjunction with a release order shall incorporate a written service plan prepared by a psychiatrist familiar with the defendant’s case history and approved by the court, and shall contain any conditions that the court determines to be reasonably necessary or appropriate. It shall be the responsibility of the Commissioner to determine that such defendant is receiving the services specified in the written service plan and is complying with any conditions specified in such plan and the order of conditions.³⁰⁸

A recent Appellate Division, Third Department, decision applying the statutory standards is *In re Arto ZZ*.³⁰⁹ In this case, the defendant was a developmentally disabled individual confined in the custody of OPWDD.³¹⁰ The court observed that:

*1085 For purposes of CPL 330.20, a person with a developmental disability is considered “mentally ill” if he or she “is in need of care and treatment as a resident in the in-patient services of a developmental center or other residential facility for the ... developmentally disabled under the jurisdiction of [OPWDD].”³¹¹

Under the statutory scheme, the People had the burden to prove by a preponderance of the evidence that the defendant remained a “mentally ill” person and thus was in need of retention.³¹² Although the defendant in this case “undeniably” was diagnosed with multiple mental health conditions in addition to being intellectually disabled, such diagnoses are, as a matter of law, “insufficient to prove that he was ‘mentally ill’ under the applicable statutory definition.”³¹³

The report and affidavit of [the Commissioner’s] expert indicated that respondent had improved such that he no longer required inpatient care and instead could function in a supervised intermediate care facility. The [People’s] expert disagreed, opining that respondent met the definition of “mentally ill” because he needed constant supervision. Supreme Court reasonably discounted that expert’s opinion because ... he generally worked with mentally ill individuals who did not have developmental disabilities and he was not sufficiently familiar with OPWDD facilities and procedures. He also engaged in baseless speculation about respondent possibly eloping from the proposed residence and the potential difficulties in locating or returning him; [with the Appellate Division holding that] such speculation cannot support the [People’s] burden. [Further, c]ontrary to the expert’s testimony, [a defendant can] be deemed no longer mentally ill [under the statute,] even if he ha[s] a psychiatric diagnosis and still [requires] supervision[, because a] “release order directs [the Commissioner] to terminate the defendant’s in-patient status without ending his [or her] *1086 responsibility for the defendant.”³¹⁴

A release order is to be distinguished from a discharge order under the statutory scheme:

The [C]ommissioner may apply for a discharge order ... when [the individual] has been [continually] on an out-patient status [(subject to an order of conditions)] for three years ... and the [person] ... no longer has a dangerous mental disorder and is no longer mentally ill and ... the issuance of a discharge order is consistent with the public safety and welfare of the community and the [individual].³¹⁵

7. Recommitment

For defendants, perhaps the most onerous aspect of the statutory scheme is the authority of the Commissioner or the District Attorney to seek the defendant’s recommitment to secure psychiatric confinement when it is alleged that a conditionally released defendant has lapsed into a dangerous mental disorder.³¹⁶ Specifically, at any time while an order of conditions remains in effect, the Commissioner or a District Attorney may apply to the court that issued the order, or a superior court in the county where the track-one defendant then resides, for a recommitment order when, in the applicant’s view, the defendant again exhibits a dangerous mental disorder.³¹⁷ “Upon receipt of [the] application[,] the [judge] must order the defendant to appear ... for a hearing to determine [his mental status].”³¹⁸ This order takes the form of a written notice of the time and place of appearance, served either personally or by mail.³¹⁹ Should “the defendant fail[] to appear in court as directed, the [judge] may issue a warrant ... [directing a] peace officer ... to take [him] into custody and bring him before the court, ... [and] may direct that the defendant be confined in an appropriate institution.”³²⁰ At the hearing, the applicant must satisfy to the judge that the defendant suffers from a dangerous *1087 mental disorder.³²¹ “If the applicant succeeds, the judge must issue a recommitment order, again consigning the defendant to a secure facility for care and treatment for six months. The periodic retention reviews then begin anew.”³²²

As interpreted by the Court of Appeals, a defendant can be returned to psychiatric confinement under the CPL without the enhanced procedural due process protections afforded to people subject to civil hospitalization, even if the person was placed in track-two or track-three at his initial hearing, upon a finding that he did not have a dangerous mental disorder.³²³ The appellate courts in New York have been completely “unpersuaded that the initial findings of a ... criminal court placing [defendants] in one of the three available ‘tracks’ has any constitutional significance.”³²⁴ “All such persons have committed

criminal acts, and this underlies the permissible distinction between them and all others”³²⁵

Federal constitutional challenges to the New York statutory scheme have to date failed, albeit narrowly.³²⁶ In addition to the recommitment remedy, the Court of Appeals also sanctioned the issuance of temporary confinement orders, authorizing the detention of conditionally released defendants for the purpose of evaluation, even though there is no statutory authorization for such a procedure.³²⁷ Reversing the Appellate Division,³²⁸ a divided Court of Appeals held that the legislature did not “displace a court’s ability to fashion” a remedy to “detect or redress the deterioration of a track-one defendant’s mental health,” and further refused to accept the defendant’s constitutional arguments.³²⁹ The majority rejected the arguments that the more broadly applicable provisions of the Mental Hygiene Law are available to address the *1088 circumstances of any individual in the community who might require evaluation for admission to a hospital.³³⁰

C. Revisiting *George L.* and the Presumption of Dangerousness

The Court of Appeals’ seminal precedent in *George L.* seized upon the “presumption that the mental illness found to have caused the defendant’s dangerousness continues after the commission of the crime, is even stronger in cases like the one before us where the defendant’s ‘antisocial behavior’ constituted a crime of violence.”³³¹ The authority for this statement was a law review student Note observing that the recent commission of a violent act significantly increases the probability that an individual will commit further such acts in the future.³³² Quoting the Note, the Court of Appeals stated: “This judgment is not simply a popular notion; the clinical consensus is that a history of violent behavior in an individual is the single best predictor of future violence [and] is supported by studies of insanity acquittees, which indicate a recidivism rate equal to that of prison populations.”³³³

Combined with the *George L.* decision in 1995 was an administrative decision made by the OMH in 1997 to “utilize the HCR-20 risk assessment instrument ... in part, [as] an attempt to implement the *George L.* [decision] through a validated risk assessment instrument.”³³⁴ According to Miraglia and Hall, though not a “perfect fit” with *George L.*, the HCR-20 provided “both contextual and longitudinal perspectives on violence risk assessment as well as a focus on risk management strategies that program managers felt was a practical approach to implementing the tenets of case law.”³³⁵ Nonetheless, it is apparent that decisions made at the Commissioner’s office to advance a person from secure *1089 to non-secure (or civil confinement) “became more structured and complex over time” and also occurred during a time that the OMH became, according to Miraglia and Hall, “increasingly risk averse.”³³⁶

Lengths of stay became longer for people committed under the CPL despite the fact that the length of hospitalization had little or no effect on re-arrest.³³⁷ Further, statistical trends demonstrated that the “while the number of [not responsible] admissions to hospitals in New York State ... declined over the past three decades from a high of 77 in 1982 to a low of 22 in 2008, the length of hospitalization of these individuals increased significantly.”³³⁸ Over “40 percent of those admitted in the 1980s were released into the community within seven years of admission.”³³⁹ During the 1990s, “only 21 percent of the admissions were released into the community within seven years.”³⁴⁰ “At the [beginning] of the last decade, only eight percent of admissions were released within a seven-year period.”³⁴¹ As stated by Miraglia and Hall, the “treatment of mental illness is an extraordinarily individualized endeavor,” and the length of stay for defendants found not responsible in New York had less to do with “treatment resistance or cognitive limitations,” and rather, was “clearly influenced by exogenous legal considerations and administrative practices.”³⁴²

As the Court of Appeals held in 1979 in *In re Torsney*: “Beyond automatic commitment of persons found not guilty by reason of mental disease or defect for a reasonable period to determine their 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.”³⁴³ Largely based upon lingering presumptions that the defendant acquitted by reason of mental disease or defect is a perpetually dangerous person, the result is a commitment scheme by interpretation and application that is increasingly onerous, bearing little resemblance to article 9 (civil) commitments.³⁴⁴

[D]efendants committed to the custody of the Commissioner *1090 pursuant to ... 330.20 have significantly longer lengths of stay than [would] be warranted by their clinical condition [F]or those defendants found to have a dangerous mental disorder at the time of their initial hearing, the [District Attorney] will have standing to appear in all future proceedings, the commitment standard is relaxed (the need for retention can be established by a mere preponderance of the evidence),³⁴⁵ and clinical discretion to grant furloughs, conditionally release, or discharge the defendant may only be exercised by court order.³⁴⁶

It is also the reality that a commitment under [CPL section 330.20](#) can result in lifetime supervision.³⁴⁷ “That is because even upon conditional release from the hospital, court-imposed conditions of supervision may be applied indefinitely upon a mere finding of ‘good cause shown.’”³⁴⁸

IV. SUGGESTIONS FOR REFORM IN NEW YORK

A. Amendment of [CPL Section 730.40](#)

As discussed above, in 1988, the Westchester County Supreme Court struck down the automatic 90-day commitment in the case of *Ritter v. Surles*.³⁴⁹ Yet there is considerable confusion about the implications of *Ritter v. Surles* 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, especially in the OPWDD system. *Ritter* should be codified and the 90-day automatic commitment repealed.

B. Amendment of [CPL Section 730.60\(1\)](#)

[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 *1091 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, provided, however, that the Commissioner may designate an appropriate hospital for placement of a defendant for whom a final order of observation has been issued, where such hospital is licensed by the office of mental health and has agreed to accept, upon referral by the Commissioner, defendants subject to final orders of observation issued under this subdivision. 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.³⁵⁰

Further, [section 730.60](#) provides that if found incapacitated under a final or temporary order of observation, the sheriff “must hold the defendant in custody pending such designation by the Commissioner.”³⁵¹

There is no time limit by which the Commissioner must make a designation and the provision is particularly onerous and constitutionally infirm if it is applied to a person who was evaluated as an outpatient.³⁵² [Section 730.60](#) should be amended to clarify that defendants evaluated as outpatients should not be held in custody pending designation and otherwise to require the Commissioner to designate a facility within a time certain so as not to run afoul of the defendant’s due process rights.³⁵³ As discussed earlier, litigation in Pennsylvania demonstrated that when mental health systems lack resources, considerable delays result to the detriment of defendants with mental disabilities awaiting placements.³⁵⁴ Given the availability of outpatient commitment in New York, it is also time to require that psychiatric examiners address in their reports whether an incapacitated defendant is a *1092 candidate for outpatient as opposed to inpatient restoration.³⁵⁵

C. Codification of *Jackson v. Indiana*

The current CPL article 730 was enacted in 1970.³⁵⁶ In 1972, the U.S. Supreme Court held in *Jackson v. Indiana* that:

[A] person charged by [the] State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute the customary civil 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.³⁵⁷

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.³⁵⁸ Across jurisdictions in the United States, “[a] number of states base ... time limits on research [demonstrating] that most [defendants] will be restored [to capacity] within six months to a year, and [that] continued treatment and detention to restore competency beyond [that] time period is unnecessary.”³⁵⁹ Yet other states base the maximum treatment period on other conditions, such as the maximum possible sentence for the alleged offense.³⁶⁰

***1093** 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.”³⁶¹ Upon reaching the two-thirds maximum, the indictment is dismissed and the defendant may only continuously be retained as a civil patient.³⁶² Currently, rights guaranteed by *Jackson* may be vindicated only through motion practice,³⁶³ which may be commenced by the defendant or the Commissioner.³⁶⁴ 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.³⁶⁵ It is time for article 730 to be examined by the legislature, taking into account both social science research and case law developments, such as the Court of Appeals decision in *People v Lewis*.³⁶⁶ In *Lewis*, the Court of Appeals held that upon conversion to civil status following a *Jackson* motion, the defendant no longer is entitled to credit for time served toward the two-thirds maximum and dismissal of the indictment.³⁶⁷

As twenty other states currently do,³⁶⁸ New York should have a maximum period of court imposed retention for restoration that has a nexus to social science research and that also takes into account the needs of special populations, such as those with intellectual disabilities or dementia.

***1094 D. Practice Considerations**

Court rules implementing CPL article 730³⁶⁹ need to be updated. Currently, the regulations contemplate commitment only to the custody of OMH.³⁷⁰ 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 Information Service” (MHLS’s predecessor agency) should be changed to “Mental Hygiene Legal Service.” In addition, section 111.8 of the rules address official forms.³⁷¹ The regulation provides 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.”³⁷² At this time of this writing, there are no official forms.

It is time to consider anew the benefit of official forms following the decision in *Hirschfeld v. Stone*.³⁷³ 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.³⁷⁴ 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 defendant’s privacy interests.³⁷⁵ 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.³⁷⁶ However, the model competency report is not uniform because OPWDD was not a party in the *Hirschfeld* litigation.³⁷⁷ Toward the goal of promoting consistent practices, official forms should be promulgated.

***1095 E. Special Populations**

1. People with Intellectual Disabilities

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 commend statutory revisions.³⁷⁸ 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.³⁷⁹ While a bill was never enacted as a

result of the Law Revision Commission investigation into these compelling issues,³⁸⁰ there is no question that over twenty-five years later, people with developmental disabilities continue to encounter significant difficulties and great risk in the criminal justice system.

2. People with Mental Disabilities Charged with Sex Offenses

Incapacitated defendants and those found not responsible are susceptible to civil management as sex offenders under article 10 of the New York State Mental Hygiene Law³⁸¹ even though they have never been convicted of sex offenses.³⁸² The jurisdiction of article 10 attaches to this special population because the statutory definition of “detained sex offender” includes:

A person charged with a sex offense who has been determined to be an incapacitated person with respect to that offense and has been committed pursuant to article seven hundred thirty of the criminal procedure law ... [and a] person charged with a sex offense who has been found not responsible by reason of mental disease or defect for the commission of that offense.³⁸³

The Appellate Division, Third Department, determined that the application of article 10 to incapacitated criminal defendants does *1096 not violate their constitutional rights.³⁸⁴ In part, the appellate panel was persuaded that the “statute is not punitive in purpose or effect, and the very fact that incompetent respondents--who cannot be held responsible for criminal acts--fall under the rubric of Mental Hygiene Law article 10 demonstrates a lack of retributive intent; petitioner ‘is not seeking retribution for a past misdeed.’”³⁸⁵

Aside from the defendant’s capacity to proceed, it remains an open constitutional question in New York as to whether a person who has never been convicted of a sex offense can nonetheless be subject to indeterminate confinement as a sex offender.³⁸⁶ For those defendants found not responsible, they have admitted to the facts underlying the offense or there has been a judicial finding to that effect.³⁸⁷ Thus, the constitutional considerations differ from those that apply to incapacitated defendants. Nonetheless, defendants found not responsible may only be released from confinement upon a finding that they no longer suffer from a dangerous mental disorder and are not mentally ill.³⁸⁸ A statutory incongruence arises *1097 because the defendant’s conditional release provides the jurisdictional predicate for the invocation of article 10, potentially subjecting the defendant to civil management as a sex offender.³⁸⁹ Defendants found not responsible are already subject to inordinate lengths of stay largely unrelated to their clinical condition and potentially lifetime supervision.³⁹⁰ There seems no legitimate purpose to also subject them to article 10 jurisdiction when they are otherwise subject to court mandated treatment and supervision under the CPL. The potential for people with severe mental disabilities to be subject to article 10 is not a hypothetical concern, and whether they can receive treatment consistent with their clinical needs remains to be determined.³⁹¹

F. Reexamination of CPL Section 330.20

Stakeholders in the CPL section 330.20 process might find common ground for chapter amendments. For instance, consensus for a revision to the statutory framework that would authorize recommitment to either a secure or non-secure facility would be consistent with the defendant’s needs, permit the Commissioners to better allocate scarce resources, and still protect public safety. Currently, the statute only permits the defendant’s return to secure confinement upon a recommitment application being granted.³⁹²

Proposed changes to the statute that would eliminate references to “mental retardation” in favor of “developmental disability” and corresponding changes of “OMRDD” to “OPWDD” are long overdue and would not be a point of controversy. Further, subdivision 21 of section 330.20 should be amended to conform to the Appellate Division, Third Department, decision in *In re Jill ZZ*.³⁹³ In that *1098 case, it was held that the existing statutory restriction on the appeal of certain orders as of right under section 330.20 violated the New York State Constitution.³⁹⁴

Finally, a substantial change many would welcome is for the defendant to convert to civil status or be released upon reaching the maximum sentence that could have been imposed if the defendant had been convicted. The U.S. Supreme Court decision in *Jones v. United States* held that a person could be confined as an insanity acquittee for as long as she is mentally ill and dangerous.³⁹⁵ Thus, providing for a temporal limitation on the length of a CPL section 330.20 commitment is not a

constitutional imperative. Nonetheless, social science research indisputably demonstrates that defendants committed to the custody of the Commissioner following a not responsible adjudication are subject to considerably longer lengths of stay as compared to civil patients.³⁹⁶ Social science research provides impetus for legislative reform as well as the following legal rationale:

The effect of a violent act and subsequent insanity acquittal on the acquittee's release rights has temporal limits. The state's justification for imposing obstacles to the acquittee's release must eventually lapse, and any further confinement of the acquittee must be justified under procedures identical to those that apply in the case of civil committees. Such a convergence is implicit in a prediction-prevention approach, under which confinement is based on prediction. The significance of a violent act and insanity acquittal lessens over time, while more recent diagnostic information about the acquittee's dangerousness due to mental illness increases in its importance. At some point, the type of information that tends to establish the dangerous mental illness of violent acquittees must be considered indistinguishable from that which bears on the status of civil committees, and the peculiar posture of violent acquittees becomes irrelevant *1099 from a prediction-prevention standpoint.³⁹⁷

Thus, the question therefore is not whether procedural convergence should occur between the two groups, but when it should occur. In the absence of an empirical, prediction-based durational limit on defendant's track-one status, the hypothetical sentencing approach would best balance the interests of the public and the rights of defendants found not responsible.

V. TOWARD THERAPEUTIC JURISPRUDENCE

The intent of this article was to merge theory and practice and reveal miscarriages that are prevalent in our criminal justice system when defendants are mentally ill, developmental disabled, or burdened with cognitive deficits that impact upon their capacity and criminal responsibility. Thousands of individuals with mental disabilities languish in prisons and jails.³⁹⁸ The reasons for this tragedy have been explored in this article and are complex, but the conclusion is inescapable that the widespread closure of psychiatric hospitals contributed to an increase in the arrest and incarceration of individuals with mental disabilities. Our legal system must confront this problem.

When adjudicating the rights and interests of defendants with significant disabilities, Professor Perlin has persuasively demonstrated through his prolific scholarship that sanist³⁹⁹ legal myths dominate our legal system.⁴⁰⁰ There is no doubt that mental illness is one of the most stigmatized of social conditions and discriminatory attitudes pervade toward people with mental illness.⁴⁰¹ The stereotype of mentally ill individuals as "ticking time bombs" for instance, creeps into decisional law and serves as an example of myth trumping science.⁴⁰² To counter the biases that *1100 penetrate legal processes, and to address the interests of people with mental disabilities who are harmed by incarceration and over-punished, Perlin and many others advocate adoption of therapeutic jurisprudence.⁴⁰³ Broadly speaking, "[t]herapeutic [j]urisprudence examines whether the law and legal institutions have healing effects or detrimental effects."⁴⁰⁴ "Therapeutic jurisprudence proposes reforms that enable the legal system to focus more on problem-solving without sacrificing the rule of law and the principles that our legal system serves, such as predictability and stability."⁴⁰⁵ Therapeutic jurisprudence supports an "ethic of care."⁴⁰⁶

Not surprisingly, Perlin describes a robust insanity defense as an essential element of therapeutic jurisprudence.⁴⁰⁷ This article has explored the many ingrained disincentives to invoking the insanity defense across jurisdictions, including in New York. Professor Perlin quotes from the late Judge David Bazelon, who said: "By declaring a small number not responsible, we emphasize the responsibility of others,"⁴⁰⁸ and "the existence of the defense gives coherence to the entire fabric of criminal sentencing."⁴⁰⁹ It is telling that in New York State, thousands of individuals with mental disabilities are currently confined in state correctional facilities, yet, in contrast, the number of not responsible admissions to hospitals has "declined over the past three decades from a high of 77 in 1982 to a low of 22 in 2008."⁴¹⁰

In New York and other jurisdictions, proper application of the insanity defense coupled with reasonable lengths of stay in hospitals following a plea or verdict of not responsible could potentially begin to remedy the tragedy that has unfolded in our *1101 country resulting in the criminalization of people with mental disabilities. A viable insanity defense should be promoted along with criminal sentencing that considers an offenders' vulnerability when meting out punishment.⁴¹¹ Recognizing and compensating for the vulnerabilities of offenders with mental disabilities should yield more humane sentences, increase the use of alternative sanctions, and prompt the reform of prison conditions.⁴¹² For those people with mental disabilities who are subject to criminal processes, mental health courts and other diversion models should be

expanded.⁴¹³

VI. CONCLUSION

Ameliorating the devastating negative consequences of criminal sanctions upon people with mental disabilities will no doubt lead to improved life outcomes, fewer people in jails and prisons, and reduced costs for state and local governments.⁴¹⁴ Resources should be enhanced through state surveys to determine the actual bed capacity that is needed for civil patients and criminal court referrals to the mental health system.⁴¹⁵ For those attorneys who practice in New York, confronting bias and understanding the intricacies of the statutory schemes governing the retention care and treatment of incapacitated defendants and those found not responsible can further individual client objectives. A robust insanity defense is essential. Criminal diverse models need to be expanded. In the broader societal context, through determined advocacy and considerate application of therapeutic justice principles, lawyers and judges can contribute greatly toward reform of a criminal justice system that for more than a generation has consigned far too many defendants laboring under significant mental disabilities to jail or prison.

Footnotes

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- ¹ See Michael L. Perlin, “*Wisdom is thrown into Jail*”: *Using Therapeutic Jurisprudence to Remediate the Criminalization of Persons with Mental Illness*, 17 MICH. ST. J. MED. & L. 343, 344-45, 364-65 (2013).
- ² See *id.* at 344-45; Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 657, 660 (2003); Sol Wachtler & Keri Bagala, *From the Asylum to Solitary: Transinstitutionalization*, 77 ALB. L. REV. 915, 916 (2014).
- ³ DORIS A. FULLER ET AL., GOING, GOING, GONE: TRENDS AND CONSEQUENCES OF ELIMINATING STATE PSYCHIATRIC BEDS 1, 9 (2016), <http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf>.
- ⁴ N.Y. CRIM. PROC. LAW §§ 330.20(2), 730.10(1) (McKinney 2017) (discussing those found not responsible due to the existence of a mental disease or defect, and defining incapacitated defendants).
- ⁵ See Michael L. Perlin, “*For the Misdemeanor Outlaw*”: *The Impact of the ADA on the Institutionalization of Criminal Defendants with Mental Disabilities*, 52 ALA. L. REV. 193, 234-35 (2000).
- ⁶ Michael L. Perlin, “*The Borderline Which Separated You from Me*”: *The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375, 1381 (1997). In a poll taken in the wake of Hinckley’s acquittal, seventy-five percent of those questioned disapproved of laws allowing people to be found not guilty by reason of insanity. See Peter Margulies, *The “Pandemonium Between the Mad and the Bad”*: *Procedures for the Commitment and Release of Insanity Acquittes after Jones v. United States*, 36 RUTGERS L. REV. 793, 794 n.3 (1984). Dissatisfaction-- though somewhat more muted--was also expressed by public officials. See Steven V. Roberts, *High U.S. Officials Express Outrage, Asking for New Law on Insanity Plea*, N.Y. TIMES, June 23, 1982, at B6.
- ⁷ See *United States v. Hinckley*, No. 81-0306, 2016 U.S. Dist. LEXIS 97906, at *4 (D.D.C. July 27, 2016); Spencer S. Hsu & Ann E. Marimow, *Would-be Reagan Assassin John Hinckley Jr. to Be Freed After 35 Years*, WASH. POST (July 27, 2016), <https://www.washingtonpost.com/local/public-safety/would-be-reagan-assassin-john-w-hinckley-jr-to-be-freed-after-35-years/2016>

/07/27/04142084-5015-11e6-a422-83ab49ed5e6a_story.html?utm_term=.b54e49e6bfb3.

⁸ See June Resnick German & Anne C. Singer, *Punishing the Not Guilty: Hospitalization of Persons Acquitted by Reason of Insanity*, 29 RUTGERS L. REV. 1011, 1074 (1976).

⁹ See E. Lea Johnston, *Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness*, 103 J. CRIM. L. & CRIMINOLOGY 147, 170 (2013).

¹⁰ See Seena Fazel et al., *Use of Risk Assessment Instruments to Predict Violence and Antisocial Behavior in 73 Samples Involving 24827 People: Systematic Review and Meta-Analysis*, 345 BRIT. MED. J. e4692 (2012); Mohit Varshney et al., *Violence and Mental Illness: What is the True Story?*, 70 J. EPIDEMIOLOG & COMMUNITY HEALTH 223, 225 (2016).

¹¹ The foundational concepts in this article were first explored in a prior article written by the author, entitled: “Defense Practice Tips: Representing Clients with Mental Disabilities.” See Sheila E. Shea, *Defense Practice Tips: Representing Clients with Mental Disabilities*, in 28 N.Y. STATE DEF. ASS’N, PUBLIC DEFENSE BACKUP CENTER REPORT 8-15 (Jan.-Apr. 2013). As such, the author frequently refers back to that writing in this article.

¹² AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter DSM-5].

¹³ See *id.* at 25. In fact, the DSM contains a cautionary statement for its forensic use because there is an “imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.” *Id.*

¹⁴ See Stephen J. Morse, *Preventive Detention: Mental Disorder and Criminal Law*, 101 J. CRIM. L. & CRIMINOLOGY 885, 888-89 (2011).

¹⁵ N.Y. MENTAL HYG. LAW § 1.03(3) (McKinney 2017).

¹⁶ DSM-5, *supra* note 12, at 20.

¹⁷ MENTAL HYG. LAW § 1.03(20).

¹⁸ See DSM-5, *supra* note 12, at 165; *Depression*, NAT’L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/depression/index.shtml> (last visited Mar. 6, 2017).

¹⁹ See *Schizophrenia*, NAT’L INST. MENTAL HEALTH, <https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml> (last visited Mar. 6, 2017).

²⁰ See DSM-5, *supra* note 12, at 31.

²¹ MENTAL HYG. LAW § 1.03(22).

²² *Id.*

²³ DSM-5, *supra* note 12, at 591. In the DSM, this category of disorders was referred to as: “Dementia, Delirium, Amnesic, and Other Cognitive Disorders.” *Id.*

24 *Id.*

25 See *People v. Phillips*, 948 N.E.2d 428, 430-31 (N.Y. 2011) (noting the effect that transcortical motor aphasia, a permanent brain injury, had on defendant's language skills, speech skills, and ability to comprehend trial proceedings); DSM-5, *supra* note 12, at 594-95 tbl.1.

26 Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 J. AM. ACAD. PSYCHIATRY & L. S3, S13, (2007); see also Paul Anthony Moran, *The Epidemiology of Antisocial Personality Disorder*, 34 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 231, 234 (1999) (estimating that between forty and sixty percent of the male prison population is diagnosable with Antisocial Personality Disorder).

27 DSM-5, *supra* note 12, at 20-23; Mossman et al., *supra* note 26, at S49-S50 (explaining the factual inquiry involved in rendering a diagnosis and indicating the role that psychiatric diagnoses serves in evaluating adjudicative competence).

28 See Mossman et al., *supra* note 26, at S45.

29 E. FULLER TORREY ET AL., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 7 (2014).

30 See H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care from Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHIATRY & L. 529, 529 (2005).

31 See *id.* at 530.

32 See TORREY ET AL., *supra* note 29, at 6; see also Deborah J. Chard-Wierschem, N.Y.S. Office for People with Developmental Disabilities, Presentation: Jail v. Beds: How to Stop the Pendulum Long Enough for Transformative Discussion on Community Service Development for Individuals with Mental Illness and Developmental Disabilities, at slide 5 (Oct. 23, 2015).

33 Allen Frances, *World's Best-and Worst-Places to Be Mentally Ill*, PSYCHIATRIC TIMES (Dec. 29, 2015), <http://www.psychiatrictimes.com/blogs.world's-best-and-worst-places-be-mentally-ill>; see TORREY ET AL., *supra* note 29, at 6.

34 In New York, hundreds of state hospital patients were transferred to nursing homes in other states to reduce the inpatient psychiatric center census and achieve fiscal savings. See, e.g., *Joseph S. v. Hogan*, 561 F. Supp. 2d 280, 286-87 (E.D.N.Y. 2008); Clifford J. Levy, *New York Exports Mentally Ill, Shifting Burden to Other States*, N.Y. TIMES (Nov. 17, 2002), <http://www.nytimes.com/2002/11/17/nyregion/new-york-exports-mentally-ill-shifting-burden-to-other-states.html>.

35 Frances, *supra* note 33. Frances also observed that still even more people "fell through the cracks and became chronically homeless." *Id.* This article draws no conclusion as to whether deinstitutionalization caused homelessness, because there is considerable debate on this subject. See Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 69 (1991) (discussing the impact of institutionalization on homelessness and the distortion of policies addressing the homeless).

36 See N.Y. STATE DEP'T OF CORRS. & CMTY. SUPERVISION, UNDER CUSTODY REPORT: PROFILE OF UNDER CUSTODY POPULATION 25 tbl.19 (2016).

37 See *id.* at 25.

- ³⁸ See *id.* at 2 (discussing the different facilities and programs in which inmates reside); see also N.Y. STATE DEP'T OF CORRS. & CMTY. SUPERVISION, PROFILE OF INMATES DESIGNATED AS SERIOUSLY MENTALLY ILL UNDER CUSTODY 12-13 app. A (2013) (discussing, *inter alia*, residential mental health treatment units and intermediate care programs for inmates with serious mental illnesses).
- ³⁹ N.Y. STATE DEP'T OF CORRS. & CMTY. SUPERVISION, *supra* note 38, at 15 app. A; Donna L. Hall et al., *Predictors of General and Violent Recidivism among SMI Prisoners Returning to Communities in New York State*, 40 J. AM. ACAD. PSYCHIATRY & L. 221, 223 (2012) (describing treatment and reentry of prisoners with mental illness in New York State).
- ⁴⁰ See N.Y. STATE DEP'T OF CORRS. & CMTY. SUPERVISION, *supra* note 38, at 14 app. A. The Special Needs Units are located at “Wende (52 beds), Sullivan (64 beds), ... Clinton (20 beds), ... and Woodbourne (50 beds)” correctional facilities. *Id.*
- ⁴¹ James W. Ellis & Ruth A. Luckasson, *Mentally Retarded Criminal Defendants*, 53 GEO. WASH. L. REV. 414, 479-80, nn.365-67 (1985); Joan Petersilia, *Justice for All? Offenders with Mental Retardation and the California Corrections System*, 77 PRISON J. 358, 361-62 (1997).
- ⁴² Anna Scheyett et al., *Are We There Yet? Screening Processes for Intellectual and Developmental Disabilities in Jail Settings*, 47 INTELL. & DEVELOPMENTAL DISABILITIES 13, 14 (2009); accord Petersilia, *supra* note 41, at 361-62.
- ⁴³ HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 53 (2003), <http://www.hrw.org/sites/default/files/reports/usa1003.pdf> (“Mental health experts have described prisons as a ‘toxic’ environment for the seriously mentally ill.”); Fox Butterfield, *Study Finds Hundreds of Thousands of Inmates Mentally Ill*, N.Y. TIMES (Oct. 22, 2003), <http://www.nytimes.com/2003/10/22/us/study-finds-hundreds-of-thousands-of-inmates-mentally-ill.html>.
- ⁴⁴ See HUMAN RIGHTS WATCH, *supra* note 43, at 56-59; Butterfield, *supra* note 43.
- ⁴⁵ Wachtler & Bagala, *supra* note 2, at 917.
- ⁴⁶ See Johnston, *supra* note 9, at 169-78; cf. Private Settlement Agreement at 12-15, Disability Advocates, Inc. v. N.Y. State Office of Mental Health (S.D.N.Y. Apr. 27, 2007) (No. 02 Civ. 4002) (proposing increased protections for inmates with mental health issues).
- ⁴⁷ E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 3-6 (2010).
- ⁴⁸ DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 2 (2006).
- ⁴⁹ Press Release, The Council of State Gov'ts: Justice Ctr., Council of State Governments Justice Center Releases Estimates on the Prevalence of Adults with Serious Mental Illnesses in Jails (June 1, 2009), https://csgjusticecenter.org/wp-content/uploads/2012/12/MH_Prevalence_Study_brief_final-1.pdf.
- ⁵⁰ *Id.*
- ⁵¹ *Id.*
- ⁵² *Id.*
“Serious mental illness” ... refer[red] to the presence of one or more of the following diagnoses: bipolar disorder, schizophrenia

spectrum disorders, and major depression. Estimates [did] not include other less serious mental illnesses, such as anxiety disorders ... adjustment disorders, or acute reactive psychiatric conditions, such as suicidal thinking, which also represent[s] significant jail management concerns.

Id. The study sites included the Albany, Rensselaer, and Monroe County jails in New York State. *See id.*

53 E. FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 58 (1992).

54 *See, e.g.,* Suman Varandani, *NYC Jails Overhaul: Mayor to Spend \$130M to Reform Handling of Mentally Ill in Criminal Justice System*, INT'L BUS. TIMES (Dec. 2, 2014), <http://www.ibtimes.com/nyc-jails-overhaul-mayor-spend-130m-reform-handling-mentally-ill-criminal-justice-1731740>.

55 [Brad H. v. City of New York](#), 712 N.Y.S.2d 336, 340 (Sup. Ct. 2000).

56 *Reducing the Number of People with Behavioral Health Needs Behind Bars*, N.Y.C. MAYOR'S OFF. CRIM. JUST., <http://www1.nyc.gov/site/criminaljustice/work/bhtf.page> (last visited Mar. 7, 2017).

57 *Id.*

58 *Id.*

59 *See* N.Y. CORRECT. LAW § 137 (McKinney 2017).

60 *See* Wachtler & Bagala, *supra* note 2, at 919-20, 922-23 (noting that mentally ill inmates in New York City jails are not protected under the SHU Exclusion Law). According to a recent change in the minimum standards, though, no inmate in the custody of the New York City Department of Corrections can be placed in punitive segregation if they have "serious mental or serious physical conditions." *See* 40 Rules of N.Y.C. § 1-17 (2017). In place of punitive segregation, the Department of Corrections and Correctional Health established the Clinical Alternative to Punitive Segregation ("CAPS") program.

61 *See, e.g.,* William R. Lindsay, *Integration of Recent Reviews on Offenders with Intellectual Disabilities*, 15 J. APPLIED RES. INTELL. DISABILITIES 111, 112 (2002).

62 Lamb & Weinberger, *supra* note 30, at 531.

63 *Id.*

64 *Id.*

65 *Id.*

66 *See* H. Richard Lamb & Robert W. Grant, *The Mentally Ill in an Urban County Jail*, 39 ARCHIVES GEN. PSYCHIATRY 17, 18-19 (1982).

67 Scheyett et al., *supra* note 42, at 13.

68 *Id.*

⁶⁹ *Id.*

⁷⁰ *See* Assemb. B. 3006-D, 236th Reg. Sess. (N.Y. 2013) (enacted); Assemb. B. 9056-D, 235th Reg. Sess. (N.Y. 2012) (enacted).

⁷¹ FULLER ET AL., *supra* note 3, at 2; 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).

⁷² Miraglia & Hall, *supra* note 71, at 524.

⁷³ [People v. A.S.](#), 924 N.Y.S.2d 311, 311 (Sup. Ct. 2011).

⁷⁴ *See id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *See id.*

⁷⁹ *See id.*

⁸⁰ [Jackson v. Indiana](#), 406 U.S. 715, 738 (1972) (“[A] person charged by a state with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute the customary civil 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.”).

⁸¹ Shea, *supra* note 11, at 8.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.* at 9.

⁸⁵ *See id.*

⁸⁶ *See id.*

- ⁸⁷ *Id.*; see Mark Siegert & Kenneth J. Weiss, *Who Is an Expert? Competency Evaluations in Mental Retardation and Borderline Intelligence*, 35 J. AM. ACAD. PSYCHIATRY & L. 346, 346 (2007).
- ⁸⁸ Shea, *supra* note 11, at 9; see Richard Rogers & Jill Johansson-Love, *Evaluating Competency to Stand Trial with Evidence-Based Practice*, 37 J. AM. ACAD. PSYCHIATRY & L. 450, 453-54, 456 (2009).
- ⁸⁹ Mossman et al., *supra* note 26, at S42.
- ⁹⁰ *Id.*
- ⁹¹ See Rogers & Johansson-Love, *supra* note 88, at 454.
- ⁹² Mossman et al., *supra* note 26, at S41.
- ⁹³ *Id.* at S41-S43.
- ⁹⁴ Shea, *supra* note 11, at 9.
- ⁹⁵ See N.Y. CRIM. PROC. LAW § 730.50(1) (McKinney 2017); N.Y. MENTAL HYG. LAW § 7.09(c) (McKinney 2017).
- ⁹⁶ See Press Release, Am. Civil Liberties Union-Pa., ACLU-PA Settles Lawsuit over Unconstitutional Delays in Treatment for Hundreds of Defendants with Severe Mental Illness (Jan. 27, 2016), <https://www.aclupa.org/news/2016/01/27/aclu-pa-settles-lawsuit-over-unconstitutional-delays-treatme>.
- ⁹⁷ *Id.*
- ⁹⁸ *Id.* However, as noted by Fuller, lawsuits to remedy the rights of incapacitated defendants to the rendition of appropriate mental health care has resulted in the diversion of resources to treat civil patients. See FULLER ET AL., *supra* note 3, at 9. This is a dangerous “shell game” that can and should be addressed by surveys to “determine how many psychiatric beds are needed to meet inpatient need.” See *id.* at 9, 29.
- ⁹⁹ *Dusky v. United States*, 362 U.S. 402, 402 (1960) (internal quotation marks omitted).
- ¹⁰⁰ Mossman et al., *supra* note 26, at S5-S6.
- ¹⁰¹ N.Y. CRIM. PROC. LAW § 730.20 (McKinney 2017).
- ¹⁰² *Id.* § 730.20(1).
- ¹⁰³ Assemb. B. 6997-A, 212th Reg. Sess. (N.Y. 1989) (enacted).
- ¹⁰⁴ See CRIM. PROC. LAW § 730.10(7).
- ¹⁰⁵ Neil J. Rowe, *Defense Practice Tips: Civil Alternatives for Disposing of Criminal Proceedings of Defendants with Mental*

Disabilities, in 16 N.Y. STATE DEF. ASS'N, PUBLIC DEFENSE BACKUP CENTER REPORT 11, 11 (July-Dec. 2001); see [CRIM. PROC. LAW § 730.20\(2\), \(3\)](#). Criminal defense attorneys need to be cognizant of the consequences of requesting an article 730 examination. See BARRY KAMINS & WARREN J. MURRAY, LEXISNEXIS ANSWERGUIDE: NEW YORK CRIMINAL PROCEDURE ch. 2, pt. C, § 2.08.1 (Gary Laurie ed., 2017). Ideally, in the case of a felony complaint, counsel should advocate for a reduction of the charge to a misdemeanor or dismissal. See *infra* Part III(A)(4).

¹⁰⁶ Shea, *supra* note 11, at 9-10.

¹⁰⁷ [CRIM. PROC. LAW § 730.30\(1\)](#).

¹⁰⁸ Shea, *supra* note 11, at 10; see generally [CRIM. PROC. LAW § 730.30\(2\)-\(4\)](#) (stating what the court should and must do when examining reports).

¹⁰⁹ Shea, *supra* note 11, at 10; accord *People v. Tortorici*, 671 N.Y.S.2d 162, 164 (App. Div. 1998) (citing *People v. Gensler*, 527 N.E.2d 1209, 1212 (N.Y. 1988)); cf. *Mollen v. Matthews*, 710 N.Y.S.2d 399 (App. Div. 2000).

¹¹⁰ See *People v. Mendez*, 801 N.E.2d 382, 384 (N.Y. 2003).

¹¹¹ Peter Preiser, *Practice Commentaries*, in [CRIM. PROC. LAW § 730.30](#); *Mendez*, 801 N.E.2d at 384 (citing *People v. Christopher*, 482 N.E.2d 45, 49 (N.Y. 1985)).

¹¹² Shea, *supra* note 11, at 10.

¹¹³ While under a temporary order of observation, the defendant may still be indicted. See [CRIM. PROC. LAW § 730.40\(4\)](#). If the defendant is indicted and arraigned, the temporary order is extinguished at the end of the 90-day period. See *id.* [§ 730.40\(1\), \(5\)](#). Any indictment must be filed in a superior court within six months of the expiration of the 90-day period prescribed in the temporary order. *Id.* If no indictment is filed, the Commissioner may either release the defendant or convert the defendant to civil status if the defendant meets criteria for admission under articles 9 or 15 of the Mental Hygiene Law. See *Ritter v. Surles*, 545 N.Y.S.2d 962, 965 (Sup. Ct. 1988).

¹¹⁴ Shea, *supra* note 11, at 10.

¹¹⁵ See *id.* at 10-11.

¹¹⁶ See New York State Office of Mental Health (OMH) Division of Forensic Services Bureau of Institutional and Transitional Services (BITS), N.Y. ST. OFF. MENTAL HEALTH, <https://www.omh.ny.gov/omhweb/forensic/bits/> (last visited Mar. 7, 2017) [hereinafter *OMH-BITS*].

¹¹⁷ See [N.Y. MENTAL HYG. LAW § 15.03](#) (McKinney 2017).

¹¹⁸ See *OMH-BITS*, *supra* note 116.

¹¹⁹ See generally [N.Y. CRIM. PROC. LAW § 730.60\(1\)](#) (McKinney 2017) (noting that the statute is silent as to the time within which the Commissioner must designate an appropriate institution to receive a defendant subject to a final order of observation).

¹²⁰ *Charles W. v. Maul*, 214 F.3d 350, 355 (2d Cir. 2000) (first citing [MENTAL HYG. LAW § 9.37\(a\)](#); and then citing N.Y. COMP. CODES R. & REGS. tit. 14, § 15.7(a) (2017)).

- ¹²¹ A hypothetical case example illustrates the jeopardy faced by a defendant examined as an outpatient: Defendant is charged with misdemeanor driving while intoxicated. Weeks after the criminal charges are lodged, the defendant suffers a stroke that renders him mentally incapable of assisting with his defense. He is placed in a nursing home. His defense counsel requests an outpatient capacity evaluation pursuant to [CPL section 730.20](#). The examiners find the defendant unfit to proceed and a final order of evaluation is entered dismissing the criminal charges. Despite the fact that the criminal charges are dismissed by operation of [CPL section 730.40](#), the statute would nonetheless authorize the defendant's remand to a local jail pending a designation by the Commissioner for evaluation for admission to a hospital. *See infra* Section III(A)(5) (discussing [CPL section 730.60](#)).
- ¹²² Shea, *supra* note 11, at 11-12. In *Monaco v. Hogan* (No. 98-CV-3386, 2010 U.S. Dist. LEXIS 131545 (E.D.N.Y. Oct. 26, 2010)) it was alleged, among other things, that the OMH Commissioner violated the equal protection rights of defendants remanded to the Commissioner's custody following the issuance of final orders of observation by treating the defendants upon admission differently than other civil patients simply because they had been charged with a crime. Under the terms of a 2013 settlement, "final order" patients who were admitted to hospitals on civil status were subject to a formal or informal review by the hospital forensic committee before being afforded privileges or discharge only if there was a clinical basis for the heightened review. *See* Shea, *supra* note 11, at 12. The fact that the patient had been charged with a crime was not, in and of itself, a sufficient basis for heightened review of the patient's status. *Id.*
- ¹²³ *See* COMP. CODES R. & REGS. tit. 22, § 111.4 (providing OMH's implementation regulations for incapacitated defendants, thus demonstrating that OPWDD does not have implementation regulations).
- ¹²⁴ *See* [CRIM. PROC. LAW § 730.50\(1\)](#).
- ¹²⁵ Shea, *supra* note 11, at 12; *accord* [CRIM. PROC. LAW § 730.50\(2\), \(3\)](#). The Mental Hygiene Legal Service is an auxiliary agency of the Appellate Divisions of State Supreme Court that operates pursuant to article 47 of the Mental Hygiene Law to provide legal services and assistance to patients and residents of mental hygiene facilities. *See Mental Hygiene Legal Service: History and Purpose*, SUP. CT. N.Y., APP. DIVISION, FOURTH JUD. DEP'T, <https://www.nycourts.gov/courts/ad4/mhls/mhls-index.html> (last visited Mar. 9, 2017).
- ¹²⁶ Shea, *supra* note 11, at 12; *accord* [CRIM. PROC. LAW § 730.50\(3\)](#). New York is one of thirty states that codified statutes specifying "a maximum period of commitment, either as a certain number of years or as some proportion [for] the maximum prison sentence for the crime charged." Joseph R. Simpson, *When Restoration Fails: One State's Answer to the Dilemma of Permanent Incompetence*, 44 J. AM. ACAD. PSYCHIATRY & L. 171, 172 (2016). Ten states have no statutes that set the maximum period of retention and "[t]he remaining ... states [permit] ... indefinite commitment, but only so long as the defendant [meets] civil commitment criteria." *Id.*
- ¹²⁷ *See* Perlin, *supra* note 6, at 193 (observing that such practices may violate the Americans with Disabilities Act (42 U.S.C. §§ 12101-12213 (2012)) as interpreted by the U.S. Supreme Court in *Olmstead v. L.C.* (527 U.S. 581, 587 (1999))).
- ¹²⁸ *See* Perlin, *supra* note 6, at 207 n.97.
- ¹²⁹ *New York State Office of Mental Health (OMH): Division of Forensic Services: Forensic Psychiatric Centers*, N.Y. ST. OFF. MENTAL HEALTH, http://www.omh.ny.gov/omhweb/forensic/psychiatric_centers.htm (last visited Mar. 8, 2017).
- ¹³⁰ *See Provider Directory*, OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, <https://providerdirectory.opwdd.ny.gov/> (last visited Mar. 8, 2017). In New York, incapacitated defendants have established the right to treatment in the least restrictive environment as a matter of due process of law. *See Bernstein v. Pataki*, 233 F. App'x 21, 25 (2d Cir. 2007); *People ex rel. Jesse F. v. Bennett*, 661 N.Y.S.2d 657, 659 (App. Div. 1997); *People v. Betances*, 671 N.Y.S.2d 930, 933 (Sup. Ct. 1998). As originally enacted, [CPL section 730.60\(1\)](#) permitted the adjudication of defendants as "dangerous incapacitated person[s]." *See* Laws of May 20, 1970, ch. 996 § 730.60(1), 1970 N.Y. Laws 3369. Subsequently, in *Gomez v. Miller*, a three-judge panel of the U.S. District Court for the Southern District of New York determined that the statute violated the

equal protection clause of the U.S. Constitution. *Gomez v. Miller*, 341 F. Supp. 323, 328 (S.D.N.Y. 1972). Thereafter, in 1974, the legislature amended CPL sections 730.60(1) and 730.60(3) to eliminate the provisions that permitted the adjudication of dangerous incapacitated persons. See Laws of May 30, 1974, ch. 629 § 730.60, 1974 N.Y. Laws 1670. Consequently, unlike CPL sections 330.20(1)(f), 330.20(6), and 330.20(14), there is no provision under CPL article 730 for adjudicating someone a “dangerous incapacitated person.” Compare CRIM. PROC. LAW § 330.20(1)(f), (6), (14), with CRIM. PROC. LAW art. 730. Nor is there any authority to require that a person committed under article 730 be held at any particular facility or under any specific level of supervision. See CRIM. PROC. LAW § 330.20(12) (demonstrating that under this law, there are particular facilities and levels of supervision for persons committed).

¹³¹ Shea, *supra* note 11, at 12-13.

¹³² Assemb. B. 9056-D, 235th Reg. Sess. (N.Y. 2012) (enacted).

¹³³ See Reena Kapoor, *Jail-Based Competency Restoration*, 39 J. AM. ACAD. PSYCHIATRY & L. 311, 311 (2011).

¹³⁴ *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).

¹³⁵ OFF. OF MENTAL HEALTH, OMH GUIDANCE FOR IMPLEMENTATION OF OUTPATIENT COMPETENCY RESTORATION (OCR) 1 (2013).

¹³⁶ 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.”).

¹³⁷ See N.Y. CRIM. PROC. LAW § 730.60(1) (McKinney 2017).

¹³⁸ See *id.*

¹³⁹ Shea, *supra* note 11, at 13.

¹⁴⁰ CRIM. PROC. LAW § 730.60(6)(a)(1).

¹⁴¹ N.Y. COMP. CODES R. & REGS. tit. 14, § 540.4 (2017) (noting that escorted furloughs are limited to defendants subject to orders of retention); *id.* § 504.5 (noting that unescorted furloughs are precluded for defendants retained under temporary orders of observation, orders of commitment, or retention orders).

¹⁴² See CRIM. PROC. LAW § 730.60(6)(c).

¹⁴³ *Id.*

¹⁴⁴ Laws of June 26, 1980, ch. 549 § 730.60, 1980 N.Y. Laws 1627-28. The chapter amended was intended to provide notice to potential victims of persons committed under article 730, and was enacted after the release of a psychiatric patient from the Pilgrim Psychiatric Center and the killing of his ex-wife in 1979. See James Barron, *L.I. Mental Patient Guilty of Killing Ex-Wife*, N.Y. TIMES (Dec. 10, 1981), <http://www.nytimes.com/1981/12/10/nyregion/li-mental-patient-guilty-of-killing-ex-wife.html>.

¹⁴⁵ See DIANA JONES RITTER ET AL., MOST INTEGRATED SETTING COORDINATING COUNCIL: 2008 ANNUAL

REPORT 7 (2008), https://opwdd.ny.gov/sites/default/files/documents/misc_annualreport.pdf.

¹⁴⁶ See generally *id.* (indicating the effort being made to facilitate community integration).

¹⁴⁷ The U.S. Supreme Court in *Olmstead v. L.C.* affirmed the responsibility by each state to serve individuals with disabilities in the most integrated community settings appropriate to meet the individual's specific needs. See *Olmstead v. L.C.*, 527 U.S. 581, 607 (1999). In reaction to this decision, the Centers for Medicare and Medicaid Services ("CMS") issued policy directives to the states on how best to comply with community integration, including incentivizing the use of the § 1915(c) Home and Community Based Services ("HSBC") waiver. See OFFICE OF DISABILITY, ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., AGING AND LONG-TERM CARE POLICY: A COMPENDIUM OF CURRENT FEDERAL INITIATIVES IN RESPONSE TO THE *OLMSTEAD* DECISION 3 (2001). Since this time, there have been additional steps taken by the federal government to incentivize community integration of individuals with disabilities, including provisions in the Affordable Care Act, which, among other things, extended the Money Follows the Person ("MFP") demonstration grant program and enhanced federal funding for community services under new incentive programs, Community First Choice services, and Balancing Incentive Programs ("BIP"). See Affordable Care Act, Pub. L. No. 111-148, § 2401, 124 Stat. 297-301 (2010); *id.* § 2403, 124 Stat. 304-305; *id.* § 10202, 124 Stat. 923-927.

¹⁴⁸ *Medicaid: Introduction*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/opwdd_resources/benefits_information/medicaid/introduction (last visited July 3, 2017).

¹⁴⁹ 42 C.F.R. § 483.420(a)(11) (2017).

¹⁵⁰ *People v. Helfman*, 458 N.Y.S.2d 628 (App. Div. 1983).

¹⁵¹ See *id.* at 629.

¹⁵² *Id.* (internal citations omitted).

¹⁵³ N.Y. CRIM. PROC. LAW § 730.60(6)(c) (McKinney 2017).

¹⁵⁴ *People v. Maignan*, 39 N.Y.S.3d 859, 863 (Sup. Ct. 2016).

¹⁵⁵ *Ritter v. Surlles*, 545 N.Y.S.2d 962, 962-63 (Sup. Ct. 1988).

¹⁵⁶ See *id.* at 966.

¹⁵⁷ *Id.*

¹⁵⁸ CRIM. PROC. LAW § 730.70.

¹⁵⁹ See *id.*

¹⁶⁰ Fatma Marouf, *Assumed Sane*, 101 CORNELL L. REV. 25, 29 (2016).

¹⁶¹ *Id.*

¹⁶² Randy Borum & Solomon M. Fulero, *Empirical Research on the Insanity Defense and Attempted Reforms: Evidence toward Informed Policy*, 23 LAW & HUM. BEHAV. 117, 119 (1999).

¹⁶³ *Id.*

¹⁶⁴ *See id.*

¹⁶⁵ *See id.*

¹⁶⁶ *See id.* at 118.

¹⁶⁷ *See id.* at 123.

¹⁶⁸ *See* Marouf, *supra* note 160, at 29-31.

¹⁶⁹ *Id.* at 30; *see* Lisa A. Callahan et al., *The Volume and Characteristics of Insanity Defense Pleas: An Eight-State Study*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 331, 334-35 (1991); *see also* Bonita M. Veysey, *Gender Role Incongruence and the Adjudication of Criminal Responsibility*, 78 ALB. L. REV. 1087, 1088 (2015) (“Even though the actual numbers are quite small, the American public and attorneys alike believe that the defense is invoked frequently and principally in cases involving murder. Despite these perceptions, most cases that involve an insanity plea are not for murder charges and are cases in which the evidence of mental illness is so overwhelming that the prosecution does not contest the insanity plea.”).

¹⁷⁰ Marouf, *supra* note 160, at 30; *accord* Henry F. Fradella, *From Insanity to Beyond Diminished Capacity: Mental Illness and Criminal Excuse in the Post-Clark Era*, 18 U. FLA. J.L. & PUB. POL’Y 7, 11-12 (2007) (citing a success rate of under twenty-five percent); Heather Leigh Stangle, Note, *Murderous Madonna: Femininity, Violence, and the Myth of Postpartum Mental Disorder in Cases of Maternal Infanticide and Filicide*, 50 WM. & MARY L. REV. 699, 728 (2008) (citing a success rate of one in one thousand criminal trials); Stephen G. Valdes, Comment, *Frequency and Success: An Empirical Study of Criminal Law Defenses, Federal Constitutional Evidentiary Claims, and Plea Negotiations*, 153 U. PA. L. REV. 1709, 1723 (2005) (citing success rates ranging from 0.87% to 26%).

¹⁷¹ In addition, several states--Montana, Idaho, Utah, and Kansas--do not recognize the insanity defense, and the Supreme Court has never addressed whether the defense is constitutionally required. *See* Marouf, *supra* note 160, at 32.

¹⁷² *Id.* at 30.

¹⁷³ N.Y. PENAL LAW § 40.15 (McKinney 2017).

¹⁷⁴ *See id.* § 25.00(2).

¹⁷⁵ *See* N.Y. CRIM. PROC. LAW § 250.10(2) (McKinney 2017).

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* § 250.10(3).

¹⁷⁸ *Id.*

179 *Id.* § 250.10(5).

180 *See, e.g., Lee v. Cty. Court of Erie Cty.*, 267 N.E.2d 452, 457 (N.Y. 1971) (“A defendant’s waiver of privilege because of his plea of insanity only permits the physician to testify as to the facts which formulate the basis of his medical opinion on the question of sanity [T]he District Attorney [shall not] be permitted to use the psychiatric examination as a source of evidence which would be relevant on the issue of guilt.”).

181 *Cf. CRIM. PROC. LAW § 250.10(5)* (“[The court] may preclude introduction of testimony by a psychiatrist or psychologist concerning mental disease or defect of the defendant at trial.”).

182 *See People v. Scala*, 491 N.Y.S.2d 555, 563 (Sup. Ct. 1985).

183 *See CRIM. PROC. LAW § 330.20* (providing the section or the CPL that is applicable to a verdict or plea of not responsible).

184 *See* Warren J. Ingber, Note, *Rules for an Exceptional Class: The Commitment and Release of Persons Acquitted of Violent Offenses by Reason of Insanity*, 57 N.Y.U. L. REV. 281, 281 (1982).

185 Barbara E. McDermott et al., *The Conditional Release of Insanity Acquittees: Three Decades of Decision-Making*, 36 J. AM. ACAD. PSYCHIATRY & L. 329, 329 (2008).

186 *In re Torsney*, 394 N.E.2d 262 (N.Y. 1979), *distinguished by People v. Escobar*, 462 N.E.2d 1171 (N.Y. 1984).

187 *See In re Torsney*, 394 N.E.2d at 263.

188 *See id.* at 273 (Wachtler, J., dissenting).

189 *Id.* at 263, 265. At the time of Torsney’s case, insanity was a simple defense rather than an affirmative defense; therefore, his acquittal reflected that the People failed to prove beyond a reasonable doubt that he was sane at the time of the offense. *Id.* at 265.

190 *See* WILLIAM J. WINSLADE & JUDITH WILSON ROSS, THE INSANITY PLEA 136 (1983).

191 *In re Torsney*, 412 N.Y.S.2d 914, 915 (App. Div. 1979), *rev’d*, 394 N.E.2d 262 (N.Y. 1979). The verdict was met with criticism from the public, which saw implicit overtones of racial bias in the killing and the acquittal. *See* WINSLADE & ROSS, *supra* note 190, at 136.

192 *See* WINSLADE & ROSS, *supra* note 190, at 143.

193 *In re Torsney*, 394 N.E.2d at 263 (“Torsney was transferred to Creedmoor Psychiatric Center on March 3, 1978 [Four months later,] on July 20, 1978, pursuant to CPL 330.20 (subd 2), the Commissioner petitioned the committing court for an order discharging Torsney from his custody.”).

194 *See id.* at 263-64.

195 *In re Torsney*, 412 N.Y.S.2d at 921-22.

¹⁹⁶ See *In re Torsney*, 394 N.E.2d at 262, 272.

¹⁹⁷ Laws of June 23, 1976, § 330.20(3), 1976 N.Y. Laws 1-182.

¹⁹⁸ See *In re Torsney*, 394 N.E.2d at 267, 274.

¹⁹⁹ See *id.* at 274-75. The U.S. Supreme Court subsequently held in 1983 that “[t]he committed [insanity] acquittee is entitled to release when he has recovered his sanity or is no longer dangerous.” See *Jones v. United States*, 463 U.S. 354, 368 (1982); see also *Foucha v. Louisiana*, 504 U.S. 71, 85-86 (1992) (stating that neither a showing of mental illness nor dangerousness alone will satisfy the requirements of due process when an individual’s liberty is at stake).

²⁰⁰ *In re Torsney*, 394 N.E.2d at 264.

²⁰¹ See *id.* at 266.

²⁰² *Id.*

²⁰³ 1980 N.Y. Sess. Laws 941, 945 (McKinney).

²⁰⁴ *Report of the Law Revision Commission: The Defense of Insanity in New York State*, in 1981 N.Y. Sess. Laws 2251, 2253, 2264-65 (McKinney) [hereinafter *Report of the Law Revision Commission*].

²⁰⁵ *In re Norman D.*, 818 N.E.2d 642, 644 (N.Y. 2004).

²⁰⁶ N.Y. CRIM. PROC. LAW § 330.20(2), (6) (McKinney 2017).

²⁰⁷ *Id.* § 330.20(4).

²⁰⁸ See *id.* § 330.20(2), (5), (15).

²⁰⁹ *Id.* § 330.20(6).

²¹⁰ *In re Brian HH.*, 833 N.Y.S.2d 718, 720 (App. Div. 2007) (quoting *In re Norman D.*, 818 N.E.2d at 644).

²¹¹ *In re Norman D.*, 818 N.E.2d at 644. The “track” nomenclature does not appear in CPL section 330.20, but is derived from the Law Revision Commission report that accompanied the proposed legislation, which states: “The post-verdict scheme of proposed CPL 330.20 provides for three alternative ‘tracks’ based upon the court’s determination of the defendant’s mental condition at the time of [the initial] hearing.” *Report of the Law Revision Commission*, *supra* note 204, at 2265.

²¹² See CRIM. PROC. LAW § 330.20(1)(c), (6); *Report of the Law Revision Commission*, *supra* note 204, at 2265-66.

²¹³ See CRIM. PROC. LAW § 330.20(1)(d), (6), (7); *Report of the Law Revision Commission*, *supra* note 204, at 2265-66.

- 214 See CRIM. PROC. LAW § 330.20(7); *Report of the Law Revision Commission*, *supra* note 204, at 2265-66.
- 215 See *In re Norman D.*, 818 N.E.2d at 643.
- 216 See CRIM. PROC. LAW § 330.20(1)(f), (6); *Report of the Law Revision Commission*, *supra* note 204, at 2265-66.
- 217 See CRIM. PROC. LAW § 330.20(1)(o), (7); *Report of the Law Revision Commission*, *supra* note 204, at 2265-66.
- 218 See CRIM. PROC. LAW § 330.20(7); *In re Jill ZZ.*, 629 N.E.2d 1040, 1042 (N.Y. 1994); *People v. Flockhart*, 465 N.Y.S.2d 601, 602 (App. Div. 1983). Notwithstanding the statutory requirement that the “conditional release or discharge” of the track-two defendant must be in accordance with the provisions of the Mental Hygiene Law, the Court of Appeals held in *In re Jill ZZ.* that the conditional release of the track-two defendant must be subject to a Criminal Procedure Law order of conditions. See *In re Jill ZZ.*, 629 N.E.2d at 1043 (quoting CRIM. PROC. LAW § 330.20(7)).
- 219 See CRIM. PROC. LAW § 330.20(6), (7), (8), (12). A discharge order is defined as “an order terminating an order of conditions or unconditionally discharging a defendant from supervision under the provisions of ... section [330.20].” *Id.* § 330.20(1)(n).
- 220 *Id.* § 330.20(1)(o).
- 221 See *id.*; *In re Oswald N.*, 661 N.E.2d 679, 681-82 (N.Y. 1995).
- 222 *In re Norman D.*, 818 N.E.2d 642, 645 (N.Y. 2004).
- 223 *Id.* at 644 (citing CRIM. PROC. LAW § 330.20(6), (8)-(13)). In New York State, the OMH operates two hospitals that are designated as secure facilities: Mid-Hudson Psychiatric Center and Kirby Forensic Psychiatric Center. See Donna L. Hall, *New York State Office of Mental Health Division of Forensic Services*, OFF. MENTAL HEALTH, <http://www.omh.ny.gov/omhweb/forensic/BFS.htm> (last visited Feb. 3, 2017). The Rochester Regional Forensic Unit at Rochester Psychiatric Center is also a designated secure unit. *Id.* The OPWDD operates two secure facilities for defendants found not responsible whose underlying conditions are attributable to intellectual or other developmental disabilities. See ELLEN N. BIBEN & ROGER BEARDEN, JOINT REPORT OF INVESTIGATIONS OF ALLEGATIONS OF ABUSE AND REVIEWS OF CONDITIONS AT THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES’ VALLEY RIDGE CENTER FOR INTENSIVE TREATMENT 3-4 (2011), <https://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/CQC123011.pdf>. Those units are located at the Sunmount Developmental Center in Franklin County and the Valley Ridge Center for Intensive Treatment in Chenango County. See *id.*; Jeff Platsky, *Broome Developmental Center Closing its Doors*, PRESS & SUN BULL. (Mar. 28, 2016), <http://www.pressconnects.com/story/news/local/2016/03/28/broome-developmental-center-closing-its-doors/82338564/>.
- 224 CRIM. PROC. LAW § 330.20(1)(c). MHL section 1.03(20) defines “mental illness” as: “[A]n affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.” N.Y. MENTAL HYG. LAW § 1.03(20) (McKinney 2017).
- 225 CRIM. PROC. LAW § 330.20(1)(c), (d).
- 226 *In re George L.*, 648 N.E.2d 475 (N.Y. 1995).
- 227 See *id.* at 478.
- 228 *Id.* at 476.

229 *Id.* at 477.

230 *Id.*

231 *Id.*

232 *Id.* at 477-78. Specifically, the trial court found that the People sustained their burden of the danger of relapse “at any time” and because there was a short time between the commission of the acts which led to the indictment and initial hearing providing in the court’s view, “an insufficient basis upon which to make a determination as to petitioner’s long-term stability for purposes of transfer to a non-secure facility.” *Id.*

233 *In re George L.*, 612 N.Y.S.2d 945, 946 (App. Div. 1994).

234 *In re George L.*, 648 N.E.2d at 479-80.

235 *See id.* at 480.

236 *Id.* at 481. Although the statute is silent as to the quantum of proof needed to satisfy the court in a commitment proceeding, the Court of Appeals held in *People v. Escobar* that preponderance of the evidence is the applicable standard of proof. *People v. Escobar*, 462 N.E.2d 1171, 1174, 1175 (N.Y. 1984).

237 *Miraglia & Hall*, *supra* note 71, at 526.

238 *See Francis S. v. Stone*, 221 F.3d 100, 112 (2d Cir. 2000). The Second Circuit observed that a track-two defendant’s equal protection argument--that following his release, he could not be recommitted to a secure hospital under the provisions of the Criminal Procedure Law--had “considerable force,” but denied habeas relief because of the restricted scope of review imposed on federal courts. *See id.* at 113, 117. The defendant’s claim was premised upon two prior explicit state court findings that he did not suffer from a dangerous mental disorder. *See id.* at 103.

239 N.Y. CRIM. PROC. LAW § 330.20(8) (McKinney 2017).

240 *Id.*

241 *Id.*

242 *Id.* § 330.20(1)(g)-(i); (8), (9).

243 *Id.* § 330.20(8), (9), (11).

244 *Id.* § 330.20(8), (9), (12).

245 *Id.* § 330.20(1)(l).

246 *Id.* § 330.20(1)(m).

247 *See id.* § 330.20(8), (9).

248 *Id.* § 330.20(11).

249 *Id.*

250 *Id.*

251 *Id.*

252 *Id.*

253 *In re Arto ZZ.*, 806 N.Y.S.2d 258, 259 (App. Div. 2005).

254 *Id.* at 259-60.

255 *See id.* at 259.

256 *See id.* at 259-60.

257 *See Henry OO. v. Main*, 763 N.Y.S.2d 154, 156 (App. Div. 2003).

258 *McGraw v. Wack*, 632 N.Y.S.2d 135, 137 (App. Div. 1995).

259 *See In re Jamie R. v. Consilvio*, 844 N.E.2d 285, 287-88 (N.Y. 2006).

260 *In re David B.*, 766 N.E.2d 565 (N.Y. 2002).

261 *In re David B.*, 766 N.E.2d at 567.

262 N.Y. CRIM. PROC. LAW. § 330.20(1)(d) (McKinney 2017).

263 *See In re David B.*, 766 N.E.2d at 571 n.5; *see also Foucha v. Louisiana*, 504 U.S. 71, 81 (1992) (distinguishing Louisiana's statute from the U.S. Supreme Court case of *Salerno*, where a showing of dangerousness was necessary for confinement); *Jones v. United States*, 463 U.S. 354, 363-64 (1983) (indicating a need to show dangerousness to justify commitment).

264 *In re David B.*, 766 N.E.2d at 570.

265 *Id.* at 567, 571.

266 *Id.* at 571, 572.

267 *Id.* at 572-73 (internal citation omitted).

268 *In re Richard S.*, 776 N.Y.S.2d 604 (App. Div. 2004).

269 *In re David B.*, 766 N.E.2d at 573.

270 *In re Richard S.*, 776 N.Y.S.2d at 604, 607.

271 *Id.* at 607.

272 *Id.*

273 *Id.*

274 *In re Richard S.*, 818 N.E.2d 668 (N.Y. 2004).

275 *Kansas v. Crane*, 534 U.S. 407 (2002). The U.S. Supreme Court held in *Kansas v. Crane* “that there must be proof of serious difficulty ... controlling behavior” in order to authorize the commitment of a sexually violent predator. *Id.* at 413.

276 *See Richard S. v. Carpinello*, 628 F. Supp. 2d 286, 288 (N.D.N.Y. 2008), *aff’d*, 589 F.3d 75 (2d Cir. 2009), *cert. denied*, *Richard S. v. Hogan* 562 U.S. 951 (2010).

277 *See id.* at 291.

278 *Id.* at 287; *see Richard S.*, 589 F.3d at 76.

279 *See Richard S.*, 589 F.3d at 83 (citing *Richard S.*, 628 F. Supp. 2d at 293).

280 *Kansas v. Hendricks*, 521 U.S. 346 (1997).

281 *Richard S.*, 589 F.3d at 83 (first citing *Hendricks*, 521 U.S. at 358; and then citing *Kansas v. Crane*, 534 U.S. 407, 413 (2002)).

282 *Richard S.*, 589 F.3d at 83.

283 “State and federal courts have been non-uniform in their interpretation of *Crane* with respect to ... whether a separate finding” regarding serious difficulty to control behavior is required, but *Richard S.* adopted the majority view. *See McGee v. Bartow*, 593 F.3d 556, 573 (7th Cir. 2010) (citing *Richard S.*, 589 F.3d at 83-84).

284 *See Richard S.*, 589 F.3d at 86 (citing *Crane*, 534 U.S. at 413, 414); *see also Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (discussing that involuntary commitment requires a finding of both mental illness and dangerousness (citing *Jones v. United States*, 463 U.S. 354, 362, 369 (1983))).

285 *Richard S.*, 589 F.3d at 84 (citing *Crane*, 534 U.S. at 413).

286 *Richard S.*, 589 F.3d at 86.

287 See N.Y. CRIM. PROC. LAW § 330.20(10) (McKinney 2017).

288 See *id.*

289 *Id.*; see N.Y. COMP. CODES R. & REGS. tit. 14, § 541.6(a) (2017).

290 *In re James Q.*, 997 N.Y.S.2d 825 (App. Div. 2014).

291 See *id.* at 827 (citing CRIM. PROC. LAW § 330.20(10)).

292 *In re James Q.*, 997 N.Y.S.2d at 827 (citing CRIM. PROC. LAW § 330.20(6)).

293 *In re James Q.*, 997 N.Y.S.2d at 827 (citing CRIM. PROC. LAW § 330.20(8), (9)).

294 *In re James Q.*, 997 N.Y.S.2d at 827 (citing CRIM. PROC. LAW § 330.20(8), (9)).

295 *In re James Q.*, 997 N.Y.S.2d at 827 (citing CRIM. PROC. LAW § 330.20(10)).

296 *In re James Q.*, 997 N.Y.S.2d at 827.

297 *Id.* at 827-28 (first citing *In re George L.*, 648 N.E.2d 475, 478 (N.Y. 1995); then citing *People v. Escobar*, 462 N.E.2d 1171, 1172-73 (N.Y. 1984); then citing *In re Amir F.*, 941 N.Y.S.2d 352, 354 (App. Div. 2012); and then citing *In re Michael RR.*, 663 N.Y.S.2d 317, 319 (App. Div. 1997), *appeals dismissed*, 692 N.E.2d 132 (1998), 700 N.E.2d 1223 (1998)).

298 *In re James Q.*, 997 N.Y.S.2d at 828.

299 *Id.* (emphasis added).

300 *Id.* (first quoting CRIM. PROC. LAW § 330.20(10); then citing *In re Kardos v. Ryan*, 814 N.Y.S.2d 336, 338 (App. Div. 2006); and then citing *In re Phillips v. Town of Clifton Park Water Auth.*, 626 N.Y.S.2d 865, 866 (App. Div. 1995)).

301 *In re James Q.*, 997 N.Y.S.2d at 828.

302 *Id.* at 829.

303 CRIM. PROC. LAW § 330.20(12).

304 *Id.*

305 *Id.*

306 *Id.*

307 *Id.*

308 *Id.*

309 *In re Arto ZZ.*, 994 N.Y.S.2d 455 (App. Div. 2014). Arto ZZ. is the same respondent whose transfer to a non-secure facility was the subject of litigation. *See id.* at 456.

310 *See id.* at 456.

311 *See id.* at 457 (quoting CRIM. PROC. LAW § 330.20(1)(d)).

312 *See* CRIM. PROC. LAW § 330.20(12); *People v. Escobar*, 462 N.E.2d 1171, 1172 (N.Y. 1984).

313 *See In re Arto ZZ.*, 994 N.Y.S.2d at 457 (first citing CRIM. PROC. LAW § 330.20(1)(d); and then citing *In re David B.*, 766 N.E.2d 565, 573 (N.Y. 2002)) (“[T]he statutory language limits the class of retained mentally ill individuals to those who must have inpatient care and treatment,” among other requirements.” (citations omitted)).

314 *In re Arto ZZ.*, 994 N.Y.S.2d at 458 (first citing *In re George L.*, 648 N.E.2d 475, 481 (N.Y. 1995); and then quoting *In re Allen B. v. Sproat*, 14 N.E.3d 970, 973 (N.Y. 2014)); *see also* CRIM. PROC. LAW § 330.20(1)(m) (defining “release order”).

315 CRIM. PROC. LAW § 330.20(13).

316 *See id.* § 330.20(14).

317 *Id.* Even if an order of conditions is not currently in effect, such an order may be issued *nunc pro tunc* so as to not defeat the court’s subject matter jurisdiction to entertain a recommitment application. *See In re Lloyd Z.*, 575 N.Y.S.2d 327, 327-28 (App. Div. 1991).

318 CRIM. PROC. LAW § 330.20(14).

319 *Id.*

320 *Id.*

321 *See id.*

322 *See In re Allen B. v. Sproat*, 14 N.E.3d 970, 974 (N.Y. 2014) (first citing CRIM. PROC. LAW § 330.20(14); and then citing *id.* § 330.20(1)(f)).

323 *See People v. Stone*, 536 N.E.2d 1137, 1139-40 (N.Y. 1989).

324 *In re Lloyd Z.*, 575 N.Y.S.2d 327, 328 (App. Div. 1991).

325 *Id.* (citing *Jones v. United States*, 463 U.S. 354, 370 (1983)).

326 *See Francis S. v. Stone*, 221 F.3d 100, 113 (2d Cir. 2000).

327 *See In re Allen B.*, 14 N.E.3d at 978 n.2, 979.

328 *See id.* at 979; *In re Robert T. v. Sproat*, 955 N.Y.S.2d 134, 140-41 (App. Div. 2012).

329 *In re Allen B.*, 14 N.E.3d at 978. Judge Lippman's dissent in *In re Allen B. v. Sproat* noted: While the state urge[d] that its objective is modest--simply to allow for the "effective examination" of the defendant--[the remedy was] remarkably vague about what that [would] entail, either temporally or psychiatrically, and [that] it [was], in any event, axiomatic that "commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection." *Id.* at 981 (Lippman, C.J., dissenting) (quoting *Addington v. Texas*, 441 U.S. 418, 425 (1979)).

330 *See In re Allen B.*, 14 N.E.3d at 982 n.2.

331 *In re George L.*, 648 N.E.2d 475, 480 (N.Y. 1995).

332 *See id.* (quoting Ingber, *supra* note 184, at 295-96).

333 *In re George L.*, 648 N.E.2d at 480 (quoting Ingber, *supra* note 184, at 295-96). However, the author went on to conclude that "[t]he effect of a violent act and subsequent insanity acquittal on the acquittee's release rights has temporal limits." Ingber, *supra* note 184, at 326 ("The state's justification for imposing obstacles to the acquittee's release must eventually lapse, and any further confinement of the acquittee must be justified under procedures identical to those that apply in the case of civil committees.").

334 Miraglia & Hall, *supra* note 71, at 526 ("The HCR-20 is a structured-judgment risk assessment instrument that is frequently used in forensic populations. It includes a scale of 10 historical domains, 5 clinical domains, and 5 risk management items that the research literature suggests are related to violence in a forensic mental health population.").

335 *Id.* ("OMH conducted systemwide training on the use of the HCR-20 and incorporated the 20 domains throughout its multi-tiered review process.").

336 *Id.*

337 *See id.* at 524.

338 *See id.*

339 *Id.*

340 *Id.*

341 *Id.* at 524-25.

342 *Id.* at 533.

343 *In re Torsney*, 394 N.E.2d 262, 266 (N.Y. 1979).

344 *See id.* at 265-66, 271.

345 This lower burden of proof is in contrast to the clear and convincing evidence standard afforded all other candidates for civil commitment in New York, even sex offenders who have been convicted, not acquitted, of the offenses providing the jurisdictional predicate for the commitment. *See* N.Y. MENTAL HYG. LAW § 10.07(d) (McKinney 2017).

346 Shea, *supra* note 11, at 14.

347 *See, e.g., In re Oswald N.*, 661 N.E.2d 679, 682 (N.Y. 1995).

348 Shea, *supra* note 11, at 14.

349 *Ritter v. Surlles*, 545 N.Y.S.2d 962, 966 (Sup. Ct. 1988).

350 CRIM. PROC. LAW § 730.60(1).

351 *Id.*

352 *See, e.g., supra* Part III(A)(5).

353 *See, e.g., Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1121-22 (9th Cir. 2003) (“[Oregon State Hospital] violate[d] the substantive due process rights of incapacitated criminal defendants when it refuse[d] to admit them in a timely manner.”).

354 *See, e.g., J.H. v. Dallas, AM. CIV. LIBERTIES UNION-PA.*, <http://www.aclupa.org/dallas> (last visited Jan. 31, 2017) (discussing the excessive length of some weight and their unconstitutional nature).

355 *See* CRIM. PROC. LAW § 730.30 (codifying the requirements for determining capacity, but lacking any stipulation regarding inpatient or outpatient candidacy).

356 *See* CRIM. PROC. LAW art. 730.

357 *Jackson v. Indiana*, 406 U.S. 715, 738 (1972).

358 *See generally* CRIM. PROC. LAW art. 730 (lacking any codification of the *Jackson* standard for time limits); *People v. Elizabeth P.*, 935 N.Y.S.2d 833, 838 (Sup. Ct. 2011) (“When *Jackson* became law in 1972, New York did not amend article 730 to address *Jackson* hearings, nor did it create any new statutory scheme to set forth the procedural mechanisms for *Jackson* relief.”).

359 JUSTICE POLICY INST., WHEN TREATMENT IS PUNISHMENT: THE EFFECTS OF MARYLAND’S INCOMPETENCY

TO STAND TRIAL POLICIES AND PRACTICES 2 (2011),
http://www.justicepolicy.org/uploads/justicepolicy/documents/when_treatment_is_punishment-full_report.pdf.

- 360 *See id.* at 34-35. The report contains a chart with maximum defined capacity restoration period for each state in the United States.
Id.
- 361 *See* [CRIM. PROC. LAW § 730.50\(3\)](#).
- 362 *See id.* § 730.50(4).
- 363 *See, e.g., Elizabeth P.*, 935 N.Y.S.2d at 838 (“*Jackson* relief is sought by established procedural mechanisms, outside the express provisions of article 730.”).
- 364 Shea, *supra* note 11, at 8 n.3 (“The Commissioner having custody of the client (Office of Mental Health or OPWDD), defense counsel or the Mental Hygiene Legal Service may seek *Jackson* relief”).
- 365 *See* [N.Y. MENTAL HYG. LAW § 43.03\(c\)](#) (McKinney 2017) (“Fees due the department for such services shall be paid by the county in which such court is located”); [CRIM. PROC. LAW § 730.20\(7\)](#) (“Such fees and traveling expenses and the costs of sending a defendant to another place of detention or to a hospital for examination, of his maintenance therein and of returning him shall, when approved by the court, be a charge of the county in which the defendant is being tried.”).
- 366 [People v. Lewis](#), 742 N.E.2d 601 (N.Y. 2000).
- 367 *See id.* at 607 (“Incidental to the exercise of his rights under *Jackson v. Indiana*, this defendant brought himself outside the four corners of CPL article 730 and, thus, was no longer entitled to avail himself of [CPL 730.50](#)’s dismissal provisions, a prospective benefit that existed before he invoked his rights under *Jackson*.”).
- 368 *See* JUSTICE POLICY INST., *supra* note 359, at 32, 34-35.
- 369 N.Y. COMP. CODES R. & REG. tit. 22, § 111.2 (2017).
- 370 *See id.* § 111.4.
- 371 *Id.* § 111.8.
- 372 *Id.*
- 373 *See* [Hirschfeld v. Stone](#), 193 F.R.D. 175 (S.D.N.Y. 2000).
- 374 *See id.* at 181.
- 375 *See id.* at 192.
- 376 *See id.* at 192, 193.

377 *See id.* at 178.

378 Assemb. B. 11695-A, 213th Reg. Sess. (N.Y. 1990) (enacted).

379 *See id.*

380 *See id.*

381 *See* N.Y. MENTAL HYG. LAW § 10.05(a), (d), (e) (McKinney 2017).

382 *See id.* § 10.05(d), (e).

383 *Id.* § 10.03(g)(2)-(3).

384 *In re State v. Daniel OO.*, 928 N.Y.S.2d 787, 795 (App. Div. 2011). There was no further appeal to the Court of Appeals because the Appellate Division decision and order was non-final and the respondent in that case was later order confined under article 15 of the Mental Hygiene Law, and not article 10, pursuant to a settlement by the parties and in an unreported order. *See In re State v. Daniel OO.*, 995 N.E.2d 849, 849 (N.Y. 2013) (“Appeal dismissed ... by the Court of Appeals, *sua sponte*, upon the ground that the stipulation and order of Supreme Court is not a final judgment ... because the Mental Hygiene Law article 10 application was withdrawn without prejudice to renewal in the event of certain conditions.”).

385 *Daniel OO.*, 928 N.Y.S.2d at 793 (quoting *Kansas v. Hendricks*, 521 U.S. 346, 362 (1997)).

386 The Mental Hygiene Legal Service (“MHLS”) sued in its agency capacity in federal court challenging certain provisions of article 10 as facially unconstitutional. *See Mental Hygiene Legal Serv. v. Cuomo*, 785 F. Supp. 2d 205, 209 (S.D.N.Y. 2011). The District Court issued a preliminary injunction holding, in part, that due process “plainly requires that an individual be found to have committed a criminal offense *beyond a reasonable doubt* before the state may subject him or her to the stigma of being labeled a ‘sexual offender.’” *Id.* at 216. The federal court enjoined the state from proceeding under article 10 against “[any] person charged with a sex offense [and] determined to be an incapacitated person with respect to that offense ... pursuant to [CPL article 730] ... unless [there was a jury finding, or a finding by the court if a jury trial was waived, that,] *beyond a reasonable doubt* that the [person] engaged in the conduct constituting the underlying offense.” *Id.* at 211 n.2, 213 n.8. The injunction was later reversed and the complaint dismissed with the Second Circuit holding that MHLS did not possess associational or third party agency standing to interpose the constitutional claims on behalf of its constituents. *See Mental Hygiene Legal Serv. v. Cuomo*, 609 F. App’x 693, 695 (2d Cir. 2015).

387 *See* N.Y. CRIM. PROC. LAW § 220.15(5)(a) (McKinney 2017). Before accepting a plea of not responsible, the court must be satisfied that each element of the offense can be established beyond a reasonable doubt; in a trial, the People have the burden of proving the elements of the offense charged. *See, e.g., In re Winship*, 397 U.S. 358, 361 (1970); *Leland v. Oregon*, 343 U.S. 790, 794, 795 (1952).

388 *See* CRIM. PROC. LAW § 330.20(12); *see also supra* Part IV(A)(6) (discussing conditional release).

389 *See* N.Y. MENTAL HYG. LAW § 10.05(b) (McKinney 2017) (“When it appears to an agency with jurisdiction that a person who may be a detained sex offender is nearing an anticipated release from confinement, the agency shall give notice of that fact to the Attorney General and to the Commissioner of Mental Health.”).

390 *See, e.g., In re Oswald N.*, 661 N.E.2d 679, 682-83 (N.Y. 1995) (citing *Jones v. United States*, 463 U.S. 354, 368-70 (1983)).

- 391 Of the 356 people confined in article 10 secure treatment facilities in October 2015, 69 were cognitively impaired and 33 were seriously mentally ill. N.Y. STATE OFFICE OF MENTAL HEALTH, 2015 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10, at 13 (2016). The OMH operates three secure treatment facilities in New York State and maintains that the needs of residents who are mentally ill, developmentally disabled, and cognitively impaired are met through special treatment tracks. *See id.* at 11-12.
- 392 *See* CRIM. PROC. LAW § 330.20(14).
- 393 *In re Jill ZZ.*, 591 N.Y.S.2d 616, 618-19 (App. Div. 1992), *rev'd on other grounds*, 629 N.E.2d 1040 (1994). In *In re Jill ZZ.*, a track-two defendant sought to appeal from an order of conditions. *Id.* at 616. As enacted, section 330.20(21) would foreclose that relief. *Id.* at 618. The Appellate Division held that the defendant's appellate remedies were guaranteed as of right by the New York State Constitution. *See id.* at 618. On the merits, the appellate panel reversed the trial court and vacated the order of conditions. *See id.* 616-18. The Court of Appeals reversed on the merits, but left undisturbed the Appellate Division's holding that the defendant had an appeal as of right from an order of conditions. *See In re Jill ZZ.*, 629 N.E.2d at 1040, 1042-43.
- 394 *See In re Jill ZZ.*, 591 N.Y.S.2d at 618 (citing N.Y. CONST. art. VI, § 4(k)).
- 395 *Jones v. United States*, 463 U.S. 354, 370 (1982).
- 396 *See* Ingber, *supra* note 184, at 327.
- 397 *Id.* at 326-27. The author refers to his proposal as the "hypothetical sentencing" approach. *Id.* at 328.
- 398 TORREY ET AL., *supra* note 47, at 5.
- 399 As Professor Perlin explains:
Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause and are reflected in prevailing social attitudes of racism, sexism, homophobia and ethnic bigotry. It permeates all aspects of mental disability law, and affects all participants in the mental disability law system: fact finders, counsel, expert and lay witnesses.
Michael L. Perlin, "You Have Discussed Lepers and Crooks": *Sanism in Clinical Teaching*, 9 CLINICAL L. REV. 683, 683 (2003).
- 400 *Id.*
- 401 *See* Varshney et al., *supra* note 10, at 223, 225.
- 402 *See* Application of Noel, 601 P.2d 1152, 1167 (Kan. 1979) (comparing considering whether a person who successfully invoked the insanity defense should be released from a hospital to shipping nitroglycerine).
- 403 Perlin, *supra* note 399, at 719.
- 404 Shirley S. Abrahamson, *The Appeal of Therapeutic Jurisprudence*, 24 SEATTLE U. L. REV. 223, 223 (2000).
- 405 *Id.*
- 406 Bruce J. Winick & David B. Wexler, *The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic*, 13 CLINICAL L. REV. 605, 605-07 (2006) ("This model contemplates lawyers practicing with an ethic of

care and heightened interpersonal skills, who seek to prevent legal difficulties or repetitive legal problems for their clients through sensitive counseling, advance planning, creative problem solving, careful drafting, and the use of alternative dispute resolution techniques.”).

⁴⁰⁷ See Michael L. Perlin, “Infinity Goes up on Trial”: Sanism, Pretextuality, and the Representation of Defendants with Mental Disabilities 5, 36 (Feb. 18, 2016) (unpublished manuscript), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2734762.

⁴⁰⁸ *Id.* at 36.

⁴⁰⁹ *Id.*

⁴¹⁰ Shea, *supra* note 11, at 14; see Miraglia & Hall, *supra* note 71, at 524.

⁴¹¹ Cf. Johnston, *supra* note 9, at 178 (discussing how certain punishments can constitute cruel and unusual punishment for those with mental illness).

⁴¹² See *id.*

⁴¹³ The New York State Office of Court Administration reported that as of January 1, 2017, there were twenty-nine mental health courts in operation, handling over 9,420 cases. See *Mental Health Courts*, NYCOURTS.GOV, www.nycourts.gov/courts/problem_solving/mh/home.shtml (last visited Feb. 2, 2017).

⁴¹⁴ See JUSTICE POLICY INST., *supra* note 359, at 31.

⁴¹⁵ See TORREY ET AL., *supra* note 47, at 12.

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