Defense Practice Tips

Representing Clients with Mental Disabilities

By Sheila E. Shea*

"It is to the Court a finding of phantom fitness with no more substance than a bubble on a baby's wand."[1]

In *People v A.S.*,[2] the Supreme Court, Kings County, rejected the opinion of a state's psychologist that A.S., a developmentally disabled client, had been restored to capacity. The case of A.S. highlights the challenges associated with representing a defendant who is mentally disabled. Charged with arson in the second degree at the age of sixteen, A.S. was intellectually disabled and unable to read beyond a first grade level. He had barely achieved a passing score on the Standardized Competency Assessment for Standing Trial for Defendants with Mental Retardation (CAST*MR) after multiple attempts during his eight year confinement at a secure developmental center. The defendant's psychiatric examiner opined that a trial would cause A.S. debilitating stress. The witness called on behalf of the Commissioner of what is now known as the Office for People with Developmental Disabilities (OPWDD) agreed; nonetheless, the Commissioner persisted in her position that A.S. was competent to stand trial. After weighing the conflicting expert testimony, the Court determined that A.S. was not competent to stand trial, seizing upon his "fragile, brittle state." Further, the Court granted the defense motion for "*Jackson*" relief[3] on the grounds that it was not likely that the defendant would attain capacity in the foreseeable future.

The case of A.S. is but one of an estimated 60,000 annually where competency evaluations are ordered in the United States. Roughly 12,000 defendants are found incompetent to stand trial each year in courts across the country.[4] Major mental illness, intellectual disability, or other cognitive limitations are the most frequent causes of adjudicative incompetence.

In New York, a defendant who as a result of mental disease or 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 common law principles, New York's statutory scheme governing fitness to proceed can be 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."[5] 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 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 (CPL),[6] but 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, engender confusion to this day. This article will attempt to demystify CPL article 730,[7] offer practice tips, and explore alternatives to criminal incarceration for defendants with mental disabilities.

Practice Tip 1: *Back to Basics.*

Crucial to understanding article 730 is familiarity with terms of art applied throughout the statute. The meanings of nine essential terms as used in article 730 are set out in the sidebar (p. 11) for easy reference by attorneys who do not regularly work with the statute.

Practice Tip 2: *Understand the Distinctions between Psychiatric Illnesses, Developmental Disabilities, and Neurological Injuries or Disorders Which Can All Impede a Client's Capacity.*

While not defined in article 730, a mental disease or defect may encompass a major mental illness, an intellectual or developmental disability, or other cognitive limitation which impedes the ability of defendants to understand the proceedings against them or assist in their own defense. The Mental Hygiene Law (MHL) defines "mental illness" as "an 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."[8] Schizophrenia and other psychotic disorders are mental illnesses within the meaning of the law. The definition of mental illness is also broad enough

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to encompass neurological disorders or conditions which impact upon brain functioning.[9]

The definition of "developmental disability" is somewhat cumbersome to those unfamiliar with the MHL or clinical practice. MHL 1.03(22) identifies six specific conditions which constitute developmental disabilities within the meaning of the law: mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, and autism. A developmental disability also includes *any other condition* of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of a person who is mentally retarded. In addition, to properly diagnose a developmental disability, the person's condition must originate before the age of twenty-two, continue or be expected to continue indefinitely, and constitute a substantial handicap to such person's ability function normally in society.[10]

Psychiatric examiners should engage in a contextual and functional analysis of the defendant's abilities when assessing that person's capacity to stand trial[11] and the clinical assessment tools utilized by the psychiatric examiner during a competency evaluation will also vary depending upon the nature of the defendant's disability. For example, the MacArthur Competence Assessment Tool (Mac CAT) and CAST*MR noted above are two commonly used instruments which assess knowledge, understanding, and reasoning pertaining to court proceedings. The Mac CAT has been validated with three groups of criminal defendants with varying competence levels and mental illness treatments histories. The CAST*MR is a standardized instrument used to assess competence for persons with mental retardation.

If a defendant is remanded for commitment following a finding that she is an incapacitated person, it is imperative that the defendant be remanded to the custody of the proper state official. This will either be the Commissioner of Mental Health (OMH), for those defendants who are mentally ill, or the Commissioner of the OPWDD, for those defendants who are developmentally disabled.[12] In some cases, a defendant will be dually diagnosed, requiring fact finding and clinical opinion as to the disorder or condition primarily contributing to the defendant's incapacity. For those clients with multiple disabilities, defense counsel may want to retain an expert who is a clinical psychologist, as opposed to a psychiatrist, in order to fully assess the client's intellectual abilities. And for clients with neurological conditions, defense counsel may want to retain a psychologist or physician with a background in neurology.

I. 730.20 — Fitness to proceed: generally

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 he has a rational as well as factual understanding of the proceedings against him."[13] The mechanics involved in having a defendant examined for the purpose of determining his or her capacity are set forth in CPL 730.20.

The appropriate director to whom a criminal court issues an order of examination must designate two qualified psychiatric examiners to evaluate the defendant. The statute was amended in 1989 to eliminate the requirement that psychiatrists be designated to examine the defendant.[14] Thus, examinations may now be conducted by two psychiatrists, two psychologists, or one from each discipline.[15]

The examination may be conducted at the place the defendant is held in custody, which is typically a local correctional facility or a hospital. If the defendant is not in custody, the examination may be conducted on an outpatient basis.[16] Significantly, unless the defendant has been admitted to a hospital, psychiatric examiners are either on the staff of or retained by the local (county or city) department of mental health. CPL 730.10(4).

Practice Tip 3: *The court may authorize a psychologist or psychiatrist retained by the defendant to be present at the psychiatric examination of the defendant (CPL 730.20[1]).*

The right to counsel attaches at a competency examination conducted pursuant to CPL article 730 and counsel may observe the psychiatric examination of his or her client.[17] There is, however, no reciprocal or corresponding right of the district attorney to either observe or videotape the examination.[18] CPL 730.20(6) makes it clear that statements made by the defendant in the course of the examination cannot be introduced as evidence against the defendant at trial on any issue other than that of the defendant's mental condition.

II. 730.30 — Fitness to proceed; order of examination

As noted in Professor Peter Preiser's *Practice Commentaries* to CPL 730.30, 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; it may be apparent from the defendant's actions in the courtroom that the court should initiate an

inquiry into fitness *sua sponte*. Most importantly, the issue for the court is not prior or subsequent incompetence, but present fitness.[19]

The examination procedure may be initiated by any court in which a criminal proceeding is pending and at any time from initial arraignment through sentencing. CPL 730.30(1). Subdivisions two, three, and four set forth the rules governing the action of the court after receipt of examination reports. The 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.[20]

In the 2011 case of *People v Philips*,[21] the Court of Appeals addressed the manner in which the court should weigh competing evidence presented on the issue of a defendant's fitness for trial. This often involves, as the Court recites, "extensive medical conclusions presented as well as the representations of defense counsel regarding his or her client's fitness for trial."[22] "[W]hile the testimony of experts and the assertions of counsel may be readily ascertained, there are other indicia of trial fitness considered by the court that may escape the record, but nonetheless evince a defendant's understanding of the proceedings. For example, the manner in which the defendant interacts with the court, communicates with defense counsel, or physically reacts to a question or piece of testimony cannot adequately be captured by the record, but has a bearing on the issue of fitness for trial and can be perceived and evaluated by the trial judge."[23] As noted above, while the representations of defense counsel are no doubt important in the court's exercise of determining fitness, they are not dispositive, but merely a factor to be considered by the trial court. A "defense counsel's observations and representations, without more, do not and should not serve as an automatic substitute for the court's statutory discretion...."[24]

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 prosecutor. CPL 730.30. When a defendant's capacity is in question, the burden is on the prosecution 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.[25]

Representing a client with diminished capacity presents particular challenges for the defense attorney. The Rules of Professional Conduct, specifically Rule 1.14, require an attorney to maintain as far as reasonably possible a conventional relationship with the client. That said, at least some judges recognize the ethical difficulties attendant to discharging representational responsibilities for a profoundly disabled client.[26] Often the attorney and the client will be aligned in asserting incapacity, but in other situations the client will claim to be fit to proceed while the defense attorney has severe doubts or cannot agree that proceeding to a hearing on fitness is in the client's best legal interests. In those cases where clients are committed and alleged to be incapacitated, but nonetheless wish to proceed to a hearing to establish fitness, representation may be assumed in some cases by the Mental Hygiene Legal Service, which avoids the ethical dilemma for defense counsel.[27]

III. 730.40 — Fitness to proceed; local criminal court accusatory instrument

Section 730.40 sets forth the procedure for the disposition of a local criminal court accusatory instrument and the commitment of the defendant to the custody of OMH or OPWDD when the court has determined that the defendant is an incapacitated person. The commitment mechanisms are either a "final order of observation" or a "temporary order of observation."

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.[28] Subdivision 1 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 cases where the court issues a temporary order of observation, the felony complaint remains open for the duration of the order; the complaint must be dismissed upon certification that the defendant was in the custody of the Commissioner when the temporary order expired.[29]

Practice Tip 4: *The automatic ninety day commitment following the issuance of a 730.40 final order of observation has been found to be unconstitutional.*

In 1988, the Westchester County Supreme Court struck down the automatic 90-day commitment in the case of *Ritter v Surles*.[30] The state elected not to appeal the order entered in *Ritter*. Instead, OMH instituted a policy in its hospitals requiring a defendant to be discharged within 72 hours following remand by the criminal court unless the defendant meets the criteria for either a voluntary or an involuntary admission to the hospital pursuant to article 9 of the MHL.[31]

OMRDD (now OPWDD), in contrast did not adopt any published policy concerning the admission and treatment of defendants remanded to the Commissioner's cus-

Definitions of Nine Essential Terms Used in Criminal Procedure Law article 730[a]

1. "Incapacitated person" means a defendant who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense.
2. "Order of examination" means an order issued to an appropriate director by a criminal court wherein a criminal action is pending against a defendant, or by a family court pursuant to section 322.1 of the family court act wherein a juvenile delinquency is pending against a juvenile, directing that such person be examined for the purpose of determining if he is an incapacitated person.
3. "*Commissioner*" means the state commissioner of mental health or the state commissioner of mental retardation and developmental disabilities (now known as the Office for People with Developmental Disabilities).
4. "Director" means (a) the director of a state hospital operated by the office of mental health or the director of a developmental center operated by the office of mental retardation and developmental disabilities, or (b) the director of a hospital operated by any local government of the state that has been certified by the commissioner as having adequate facilities to examine a defendant to determine if he is an incapacitated person, or (c) the director of community mental health services.
5. "Qualified psychiatrist" means a physician who:
   (a) is a diplomate of the American board of psychiatry and neurology or is eligible to be certified by that board; or,
   (b) is certified by the American osteopathic board of neurology and psychiatry or is eligible to be certified by that board.
6. "Certified psychologist" means a person who is registered as a certified psychologist under article one hundred fifty-three of the education law.
7. "Psychiatric examiner" means a qualified or certified psychologist who has been designated by a director to examine a defendant pursuant to an order of examination.
8. "Examination report" means a report made by a psychiatric examiner wherein he sets forth his opinion as to whether the defendant is or is not an incapacitated person, the nature and extent of his examination and, if he finds that the defendant is an incapacitated person, his diagnosis and prognosis and a detailed statement of the reasons for his opinion by making particular reference to those aspects of the proceedings wherein the defendant lacks capacity to understand or to assist in his own defense. The state administrator and the commissioner must jointly adopt the form of the examination report; and the state administrator shall prescribe the number of copies thereof that must be submitted to the court by the director.[b]
9. "Appropriate institution" means (a) a hospital operated by the office of mental health or a developmental center operated by the office for people with developmental disabilities; or (b) a hospital licensed by the department of health which operates a psychiatric unit licensed by the office of mental health, as determined by the commissioner provided, however, that any such hospital that is not operated by the state shall qualify as an "appropriate institution" only pursuant to the terms of an agreement between the commissioner and the hospital. Nothing in this article shall be construed as requiring a hospital to consent to providing care and treatment to an incapacitated person at such hospital.

[a] These definitions appear in CPL 730.10.
[b] 22 NYCRR Part 111. Procedure Under CPL article 730.

tody pursuant to CPL 730.40. Following *Ritter*, a federal lawsuit was commenced against both OMH and OMRDD asserting that even a temporary hold for evaluation for admission violated the plaintiffs' constitutional rights.[32] The Second Circuit ruled against the plaintiffs, however, and determined that the state needed some reasonable time to decide whether to initiate civil commitment proceedings and a 72-hour confinement is not excessive to accomplish an evaluation. Thus, both OMH and OPWDD should evaluate persons remanded for admission from criminal courts within 72 hours to determine if the admission criteria are satisfied. The Mental Hygiene Law also requires that MHLS receive notice of *all* admissions to psychiatric hospitals and schools for the developmentally disabled, so any individuals who are admitted to the custody of OMH or OPWDD as a consequence of a 730.40 final order of observation will have the assistance of MHLS and receive notice of their status and rights.[33]

A defendant remanded for evaluation for admission pursuant to 730.40 will most likely be received at a state-operated psychiatric hospital. However, a 2008 amendment to article 730 does permit the admission of the defendant to a private hospital licensed by OMH, provided the hospital agrees to receive the defendant.[34] 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 clinical needs.[35]

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 after the

patient's conversion to civil status.[36] These regulations require, in part, that before clinical discretion is exercised to release, change status, or grant 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.[37] The application of these more stringent regulations to patients remanded to custody of the Commissioner of OMH on final orders of observation has been the subject of long-standing federal litigation, *Monaco v Hogan*, 98-CV-3386 (EDNY), which is near settlement.[38] Under the terms of the settlement, OMH and its facilities may subject individuals remanded to OMH facilities pursuant to final orders of observation to a formal or informal review before granting them privileges or discharging them, but only if a clinical reason justifies such review. In determining whether there is clinical reason for referring such a patient for a formal, informal, or heightened review of proposed privileges or discharge, the patient's treatment team may take into consideration the nature of the charges and the circumstances which formed the basis for the charges which were dismissed when the patient was sent to the OMH facility pursuant to a final order of observation, but not simply that a patient was charged with a crime. A hearing to determine whether the settlement should be approved is set for May 16, 2013 in Federal District Court for the Eastern District of New York.

IV. 730.50 — Fitness to proceed; indictment

When a defendant is arraigned on an indictment, the superior court will proceed in accordance with CPL 730.30 to determine whether the person is an incapacitated person. If the court is satisfied that the person is not incapacitated, the criminal action against her proceeds. If the court is satisfied that the defendant is an incapacitated person, it must issue a final order of observation or an order of commitment.

If there is an indictment for a non-felony, then a final order of observation will be issued and the indictment dismissed. If the indictment is for a felony, then a commitment order is issued for a period of up to one year.

First and subsequent orders of retention may be issued upon application by the facility director where it is alleged that the defendant continues to be an incapacitated person. The court may adjudicate the defendant an incapacitated person and issue an order of retention following a hearing, initiated by the defendant or the Mental Hygiene Legal Service or upon the Court's own motion, or if no demand for a hearing is made, upon the papers.[39] In practice, the retention application is filed by OMH or OPWDD on official forms promulgated by the Office of Court Administration[40] and the MHLS attorney who receives the application will meet with the client and explain her right to a hearing. A hearing must be demanded within ten days of the date that notice of the application was given to the defendant and the Mental Hygiene Legal Service. If a hearing is requested, the MHLS attorney will transmit the demand to the criminal court that issued the original commitment order and the hearing will be held in that county. Recent litigation has focused on whether the district attorney has the right to participate in the hearing. While the prosecutor is not entitled to statutory notice of the proceeding, such notice is built into the official forms and the Appellate Division, First Department has just held that the prosecutor has standing to participate in the proceeding.[41]

An indicted incapacitated defendant may be held in the custody of the Commissioner indefinitely without achieving dismissal of the indictment, depending on the maximum prison term that defendant faces. The defendant can be held 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.[42] If the defendant is in the custody of the Commissioner and reaches the "2/3 maximum" the indictment against him must be dismissed and the dismissal constitutes a bar to any further prosecution of the charge or charges contained in the indictment.[43] If the defendant is released prior to that time, though, upon a finding that she is no longer an incapacitated person, the criminal action against her must proceed.[44] During the period of confinement in the custody of the Commissioner, the quality of the defendant's representation can be enhanced if defense counsel and attorneys for the Mental Hygiene Legal Service communicate with each other periodically toward measuring whether the defendant is making progress toward restoration of fitness and to determine whether any motions should be made which do not require the defendant's personal participation.[45]

Practice Tip 5: *If a defendant is afforded* Jackson *relief and converted to civil status, the time spent in custody on an MHL article 9 or 15 legal status does not count toward calculation of the two-thirds maximum for purposes of CPL 730.50(3) & (4).*

Where a court finds that 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.[46] Conversion to civil status typically 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*,[47] however, conversion to civil status may have adverse consequences for the defendant as the time in custody on civil

status will not count toward the two-thirds maximum and dismissal of the indictment.

Practice Tip 6: *Under CPL 730.50 an incapacitated defendant may subjected 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 (L 2012, ch 56).*

Prior to 2012, a superior court was required to commit an incapacitated defendant to an appropriate institution. The 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. It was also noted that 35 states provide for outpatient restoration of capacity and that community-based restoration would result in significant cost savings. 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.[48] Since the amendment of the statute, the Mental Hygiene Legal Service has successfully advocated for outpatient commitment in two cases in the trial courts in the Third Department. Both cases involved developmentally disabled clients committed to the custody of OPWDD. Applications for continued retention were filed in these cases, but upon the clinical recommendation of OPWDD and the consent of the prosecutors, the court authorized outpatient commitment. The courts' orders will permit both clients to continue to receive appropriate care and treatment while residing in community residences. *See also People v Betty Y.*, 2013 NY Slip Op 23063 (Supreme Ct, Kings Co 3/7/2013).

V. CPL 730.60 — Fitness to Proceed; procedure following custody by the Commissioner

This section of the CPL deals with custody following commitment under a CPL 730 order of observation.[49] The criminal proceeding is suspended while the defendant is incapacitated. 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.[50] 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.[51] Defense counsel are encouraged to contact the Mental Hygiene Legal Service to discuss the possibility of filing a CPL 730.60(5) motion.

Subdivision six of this section codifies 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. The constitutionality of section 730.60(6) as applied to final-order defendants was challenged in *Ritter v. Surles*,[52] discussed above. According to the court's decision, the Commissioner may still notify persons listed in CPL 730.60(6) of an upcoming release or change in status, but the release may not be delayed for the purpose of notification. The court also held that the district attorney no longer has criminal jurisdiction over the final-ordered defendant since all criminal charges have been dismissed.

VI. Dispositional Alternatives for the Incapacitated Defendant

• Civil Admission

Commitment to a psychiatric hospital or developmental center for any purpose constitutes a significant deprivation of liberty.[53] For those clients who are subject to orders of commitment under CPL 730.50, both OMH and OPWDD operate secure facilities where the clients will likely be confined. The OMH secure facilities which receive article 730 defendants are located at Kirby (Manhattan) and Mid-Hudson (Orange County) Psychiatric Centers or the Northeast or Rochester Regional Forensic Units.[54] Individuals who are subject to final orders of observation and remanded to the custody of the Commissioner for evaluation for admission as civil patients would likely be admitted to non-secure state or local psychiatric hospitals.[55] For developmentally disabled clients, in particular, the in-patient facilities available to receive them are few in number since OPWDD is in the process of significantly downsizing its institutional capacity.[56] Thus, a defendant subject to a CPL 730.50 commitment, for instance, would likely to be committed to a secure developmental center (often the Sunmount Developmental Center in Franklin County) where it may be difficult for counsel to maintain contact with her client.

Where the purpose of an article 730 commitment is restoration of capacity, an ancillary benefit to the client is that during the period of commitment the client may receive desperately needed treatment for a psychiatric illness or support and habilitation for a developmental disability. If the objective of the attorney is to secure therapeutic treatment and services for a client and the client will voluntary accept services, another alternative is to

pursue legal remedies which *could* result in a dismissal of the accusatory instrument, particularly when the client is charged with low level offenses, while at the same time affording the client essential services from OMH or OPWDD operated or licensed providers. As noted previously, the psychiatrists or psychologists appointed to complete an examination ordered pursuant to CPL 730.30 are typically either on the staff of or retained by the county mental health commissioner. These same individuals have the authority and responsibility to assist in a civil admission, particularly when the civil admission would be more appropriate than a criminal commitment. The detailed provisions governing admission and retention in hospitals and developmental centers pursuant to articles 9 and 15 are beyond the scope of this article, but the Mental Hygiene Legal Service can serve as a resource to the defense in explaining the operation of the statutory scheme. It is also fair to say that securing community-based (as opposed to in-patient) treatment services for mentally ill and developmentally disabled clients can be very challenging, particularly for clients who may need services to address developmental disabilities, but whose eligibility for such services has not been previously established. Mechanisms exist within OPWDD to seek eligibility determinations, however, and administrative remedies are available should eligibility be denied.[57] Again, the Mental Hygiene Legal Service can assist the defense bar in understanding eligibility criteria and advocating for appropriate services.

Less commonly utilized processes also permit a court itself to initiate a civil admission for a person brought before the tribunal. MHL 9.43(a) provides a procedure to bring an individual before a court and then, if certain standards are met, the judge may order the individual transported to a psychiatric emergency room for examination and possible admission. Criminal courts are also vested with the authority under MHL 9.43(b) to dismiss a criminal action and remand a person to a hospital for evaluation for admission. For 9.43(b) to apply, the person before the court must appear "to have a mental illness which is likely to result in serious harm to himself or others" and the court must find either that the crime has not been committed or that there is not sufficient cause to believe that such person is guilty.

- **Not Guilty by Reason of Mental Disease or Defect — CPL 330.20**

CPL article 730 addresses the fitness of the defendant to stand trial. The provisions of article 730 and the statute's purpose must be distinguished from the procedures invoked to determine the defendant's mental capacity at the time of the commission of the criminal act. The latter involves the affirmative defense of mental disease or defect,[58] a plea or verdict of not responsible,[59] and the post plea or verdict procedures applicable to persons found not responsible by reason of mental disease or defect.[60] While commentators have observed that the test for competency to stand trial requires a greater degree of mental illness than that which is necessary to mount a successful insanity defense, substantially more defendants are found incompetent to stand trial than are acquitted by reason of mental disease or defect.[61] Indeed, the number of "NGRI"[62] admissions to OMH custody has declined over the past three decades from a high of 77 in 1982 to a low of 22 in 2008.[63]

Practice Tip 7: *Defendants committed to the custody of the Commissioner pursuant to CPL 330 have significantly longer length of stay than may be warranted by their clinical condition.*

As with article 730 of the CPL, defense counsel may pursue the insanity defense to remove the client from the criminal justice system while ensuring that a client receives essential services. Counsel assisting clients with severe and persistent mental illnesses or developmental disabilities should be aware, however, that defendants committed to the custody of the Commissioner pursuant to CPL 330.20 have significantly longer lengths of stay than might be warranted by their clinical condition. Furthermore, for those defendants found to have a dangerous mental disorder at the time of their initial hearing, the prosecutor 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), and clinical discretion to grant furloughs, conditionally release, or discharge the defendant may only be exercised by court order.[64]

Counsel advising the mentally disabled defendant should also consider that a commitment under CPL 330.20 could result in a lifetime of supervision. 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."[65] Thus, in cases where the defendant is charged with a misdemeanor, in particular, invoking the insanity defense could result in a much longer period of confinement and supervision for the defendant than a sentence imposed after a finding of guilt. The better alternative if the defendant is restored to capacity may be to dispose of the criminal charges by plea with a definitive sentence and address the need for treatment under MHL article 9 or 15.

- **Assisted Outpatient Treatment — MHL 9.60**

Assisted outpatient treatment is codified at MHL 9.60 and is popularly known as Kendra's Law. Assisted outpatient treatment or "AOT" may, in some cases, provide a civil dispositional alternative for mentally ill defendants. AOT consists of court-ordered services which are deliv-

ered in accordance with a treatment plan developed by a physician in consultation with the patient. Such treatment must include either case management services or assertive community treatment team[66] services through which the patient's care is coordinated and monitored. Court orders may also include any of the following categories of services, as appropriate: medication:

—periodic blood tests and urinalysis to determine compliance with prescribed medications and individual or group therapy;

—day or partial-day programming activities, and educational and vocational training and activities;

—alcohol and substance abuse treatment; and

—supervision of living arrangements.

There are detailed procedural requirements for the initiation of a Kendra's Law proceeding and factual predicates which must precede the application, *i.e.*, the petition must plead and establish that the subject of the petition has a history of lack of compliance with treatment for mental illness. If a person who has been ordered to participate in assisted outpatient treatment fails to comply, he may be brought to a hospital and evaluated for admission on an involuntary basis pursuant to MHL article 9.

- **Mental Health Courts**

Mental Health Courts handle criminal cases involving defendants with mental illness and seek alternatives to incarceration and diversion into treatment. The courts feature a designated judge, specially-trained staff, resource coordination, and collaboration between the court, community stakeholders, local mental health departments, and mental health and social service providers. The first mental health court in New York State opened in Kings County in 1982. As of August 1, 2012, there were 28 mental health courts operating upon the approval of the Presiding Justices of the Appellate Division.[67] Significantly, a defendant's decision to participate in a mental health court should be voluntary and based upon an informed choice. Courts should establish procedures for ensuring that each participant understands the terms of participation, including the impact upon his or her criminal case and the proposed treatment options. In particular, mental health courts must address issues of competence prior to enrollment of a mentally ill defendant in the program.

Conclusion

Representing mentally disabled individuals can be a challenging, but, with knowledge and preparation, a rewarding endeavor. Article 730 of the CPL offers critical procedural and substantive due process protections for defendants unable to understand the proceedings against them or assist in their own defense. Knowledge of the mechanics of article 730 is critical to provide effective representation to mentally disabled defendants. However, counsel also needs a full appreciation of the spectrum of remedies available under civil statutes to protect the rights and interests of the mentally disabled to further clients' objectives and lead to better treatment options in less restrictive, community-based environments.

Endnotes

1. *People v A.S.*, 30 Misc 3d 1220(A) (Supreme Ct, Kings Co 2011).

2. *Id.*

3. *Jackson v Indiana*, 406 US 715 (1972). In *Jackson*, the United States Supreme Court held "that a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed at trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain capacity in the foreseeable future." *Id.* at 738; *People v Schaffer*, 86 NY2d 460 (1995). *Jackson* relief exists parallel to, but is not codified within, CPL 730. *See People v Elizabeth P.*, 34 Misc 3d 647, 653 (Sup Ct, New York Co 2011). The Commissioner having custody of the client (Office of Mental Health [OMH] or OPWDD), defense counsel or the Mental Hygiene Legal Service may seek *Jackson* relief and the procedural mechanism utilized is most typically a motion or writ of habeas corpus. *See id.* (citing *People ex rel. Trujillo v Ardito*, 109 Misc 2d 1009 [Supreme Ct, Kings Co 1981]). An application for *Jackson* relief may be initiated at any time, but is most often initiated in conjunction with the expiration of a CPL 730.50 retention order and an application to extend the commitment on the grounds that the client remains incapacitated. If granted, the client will be converted to "civil status" or released, but the indictment will not be dismissed. *People v Schaffer*, 86 NY2d 460 (1995).

4. Mental Competency — Best Practices Model, The National Judicial College (2011-2012), available at www.mentalcompetency.org/pdf/BP-Model.pdf.

5. 2 Rev Stat 697 at § 2 (1828); *Mental Illness, Due Process and the Criminal Defendant*, Fordham University Press (1968), at 73.

6. L 1970, ch 996.

7. CPL article 730, Mental Disease or Defect Excluding Fitness to Proceed.

8. MHL 1.03(20).

9. *See People v Phillips*, 16 NY3d 510 (2011) (where the client suffered from transcortical motor aphasia as a consequence of a series of debilitating strokes).

10. MHL 1.03(22); *see* OPWDD Advisory Guideline — Determining Eligibility for Services: Substantial Handicap and Developmental Disability, http://www.opwdd.ny.gov/node/1055 [accessed 02/19/2013].

11. Mental Competency — Best Practices Model, at 9.

12. CPL 730.10(3); *People v Santos*, 127 Misc 2d 63 (Supreme Ct, New York Co 1985).

13. *Dusky v United States*, 362 US 402 (1960); *People v Francabandera*, 33 NY2d 429, 436 (1974).

14. L 1989, ch 693.

15. Peter Preiser, Practice Commentaries, McKinney's Cons Laws of NY, Book 11A, CPL 730.20 at 280.

16. CPL 730.20(2), (3).

17. *People v Perkins*, 166 AD2d 737 (3d Dept 1990); *see Ughetto v Acrish*, 130 AD2d 12 (2d Dept 1987).
18. *People v Chang Rong Zhao*, 35 Misc 3d 439 (Supreme Ct, Queens Co 2012).
19. *People v Peterson*, 40 NY2d 1014 (1976).
20. CPL 730.30(2), (3); *see People v Tortorici*, 249 AD2d 588 (3d Dept 1998), *aff'd*, 92 NY2d 757 (1999); *People v Grisset*, 118 Misc 2d 450 (Supreme Ct, Queens Co 1983); *People v Grieco*, 82 Misc 2d 500 (Supreme Ct, Westchester Co 1975).
21. 16 NY3d 510 (2011).
22. *Id.* at 517.
23. *Id.*
24. *People v Morgan*, 87 NY2d 878, 880 (1995).
25. *People v Mendez*, 1 NY3d 15 (2003); *People v Santos*, 43 AD2d 73 (2d Dept 1973); *People ex rel. Ardito v Trujillo*, 109 Misc 2d 1009 (Supreme Ct, Richmond Co 1981).
26. *See People v Phillips*, 16 NY3d 510 (2011) (Lippman, CJ, dissenting).
27. *See, e.g., People v D.J.H.*, 32 Misc 3d 1231(A) (Supreme Ct, Queens Co 2011).
28. CPL 730.40(1).
29. CPL 730.40(2).
30. 144 Misc 2d 945 (Supreme Ct, Westchester Co 1988).
31. *Charles W. v Maul*, 214 F3d 350 (2d Cir 2000).
32. *Id.*
33. MHL 9.07, 15.07.
34. L 2008, ch 231. A similar amendment was inserted in sections 730.50(1) and 730.60(1), (3).
35. *Bernstein v Pataki*, 233 Fed Appx 21 (2d Cir 2007).
36. 14 NYCRR Part 540.

Additional Resources

Resources set out in this article and in the list below can help attorneys be more comfortable and capable in representing clients who are mentally disabled. Counsel can seek opportunities to consult with Mental Hygiene Legal Service Attorneys, and contact the Backup Center for assistance.

New York State

- NYS Office of Mental Health, The Mental Health Resource Handbook for Human Service Personnel Serving the Local Correctional Population http:// www.omh.ny.gov/omhweb/forensic/manual, particularly Chapter 6: MHL, CL, and CPL Commitments and Examinations: Procedures http://www.omh.ny.gov/omhweb/forensic/manual/html/chapter6.htm
- National Alliance for the Mentally Ill (NAMI) New York State and Urban Justice Center Mental Health Project, How to Help When a Person With Mental Illness is Arrested (2001) http://www.naminys.org/ images/stories/Documents/person_arrested_mental_illness.pdf
- Urban Justice Center, When a Person with Mental Illness Goes to Prison, How to Help: A Guide for Family Members and Friends (2010) http://www. urbanjustice.org/pdf/publications/mhp_08sept10.pdf

Mental Hygiene Legal Service

- *First Department:* www.courts.state.ny.us/courts/ad1/Committees&Programs/MHLS/index.shtml Departmental Office: 41 Madison Avenue, 26th Floor, New York, NY 10010, (646) 386-5891
- *Second Department:* www.courts.state.ny.us/courts/ ad2/mhls_mainpage.shtml Departmental Office: 170 Old Country Road, Suite 500, Mineola, NY 11501, (516) 746-4545
- *Third Department:* www.courts.state.ny.us/ad3/MH LS/Index.html Departmental Office: 40 Steuben Street, Suite 501, Albany, NY 12207, (518) 451-8710
- *Fourth Department:* www.nycourts.gov/courts/ad4/ MHLS/MHLS-index.html Departmental Office: M. Dolores Denman Courthouse, 50 East Avenue, Suite 402, Rochester, NY 14604, (585) 530-3050

National

- ABA Criminal Justice Standards, Mental Health http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_toc.html
- National Judicial College, Mental Competency Best Practices Model http://mentalcompetency.org
- Kentucky Department of Public Advocacy, Mental Health & Experts Manual (8th ed. 2005) http://dpa. ky.gov/NR/rdonlyres/14438F9F-FA43-4B80-B7DE-E2EAA6AF8A62/0/2005MentalHealthManual.pdf
- Bazelon Center for Mental Health Law, Diversion from Incarceration and Reentry http://www.bazelon. org/Where-We-Stand/Access-to-Services/Diversion-from-Incarceration-and-Reentry-.aspx

Mental Illnesses and Developmental Disabilities

- NAMI, Specific Mental Illnesses http://www.nami. org/Template.cfm?Section=By_Illness
- Centers for Disease Control and Prevention, Developmental Disabilities http://www.cdc.gov/ncbddd/developmentaldisabilities/index.html
- NYS Office for People with Developmental Disabilities, Facts about Developmental Disabilities http://www.opwdd.ny.gov/opwdd_resources/publications/documents/brochures_factsaboutdd

37. 14 NYCRR 540.1 *et seq.*

38. *Monaco v Hogan*, 98-CV-3386 (EDNY).

39. CPL 730.50(2); *Matter of Thomas C.*, 196 AD2d 393 (2d Dept 1994).

40. 22 NYCRR subtitle D, ch VI (Forms for Use in Courts Exercising Criminal Jurisdiction).

41. *People v Christopher B*, 102 AD3d 115 (1st Dept 2012). An application for leave to appeal to the Court of Appeals is pending.

42. CPL 730.50(3), (4); Preiser, *Practice Commentaries*, at 362.

43. CPL 730.50(4).

44. CPL 730.50(2).

45. CPL 730.60(4).

46. *Jackson v Indiana*, 406 US 715 (1972); *People v Schaffer*, 86 NY2d 460 (1995).

47. 95 NY2d 539 (2000).

48. *Bernstein v Pataki*, 233 Fed Appx 21 (2d Cir 2007).

49. Peter Preiser, Practice Commentaries, McKinney's Cons Laws of NY, Book 11A, CPL 730.60 at 374.

50. *Id.*

51. CPL 730.60(5).

52. 144 Misc 2d 945 (Supreme Ct, Westchester Co 1988).

53. *Humphrey v Cady*, 405 US 504 (1972).

54. Populations Served in OMH Forensic and SOTP Facilities, www.omh.ny.gov/omhweb/forensic/populations_served.htm.

55. CPL 730.40(1).

56. OPWDD, Statewide Comprehensive Plan: 2012-2016, www.opwdd.ny.gov/opwdd_about/strategic_plan/home [accessed 2/19/2013].

57. OPWDD, Guidance Documents, www.opwdd.ny.gov/regulations_guidance/guidance_documents [accessed 2/19/2013].

58. Penal Law 40.15.

59. CPL 220.15.

60. CPL 330.20.

61. Nancy Halleck & John Carroll, *Chapter 22–The Mentally Disabled in the Criminal Justice System, in* Representing People with Disabilities (3d ed 2007 revision).

62. Not guilty by reason of insanity. Not technically accurate, but commonly used to connote not responsible by reason of mental disease or defect, an affirmative defense. *See* Am Jur 2d Criminal Law § 76.

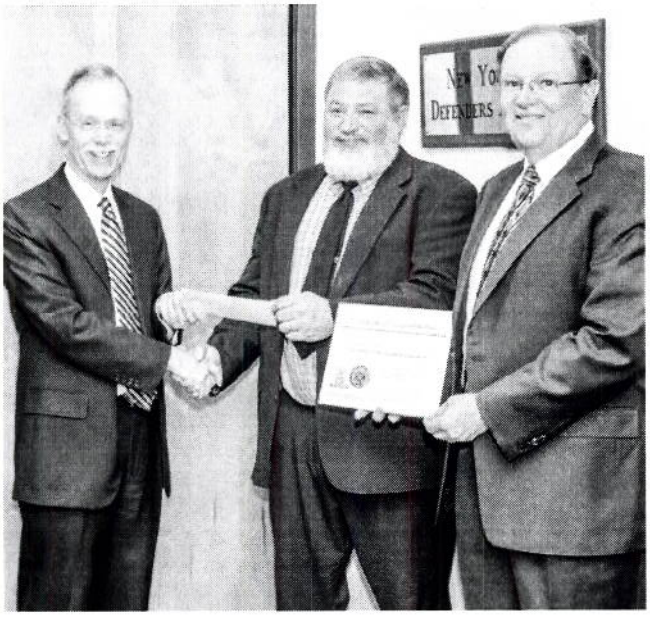
63. Richard Miraglia & Donna Hall, *The Effect of Length of Hospitalization of Re-arrest Among Insanity Plea Acquittees*, J Am Acad Psychiatry Law, 39(4), 524-534 (2011).

64. CPL 330.20(8), (9), (10), (12), (13); *Matter of Michael RR.*, 233 AD2d 30 (3d Dept 1997) *lv to appeal dismissed* 91 NY2d 921 (1998).

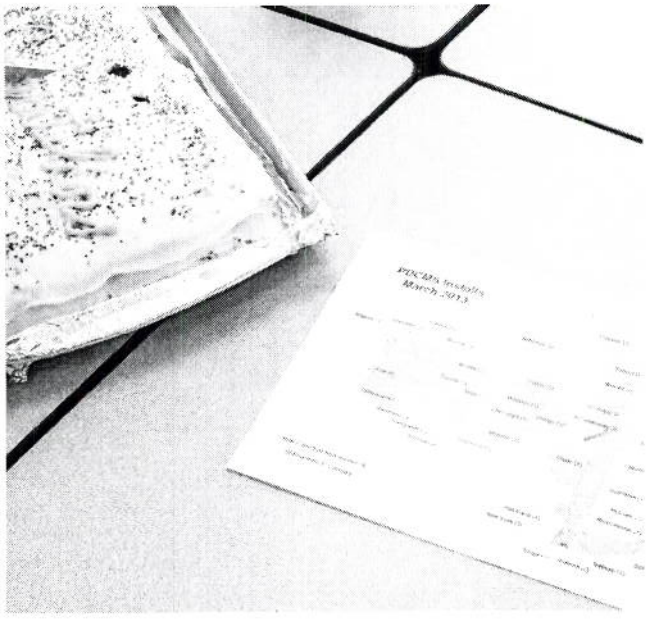
65. CPL 330.20(1)(o).

66. Authorized pursuant to MHL 7.17(f), the "assertive community treatment" or ACT teams are operated on the county level and serve high need, high priority individuals with severe mental illnesses. Services may be offered through a mobile crisis team and are inter-disciplinary in nature, typically reaching people with co-concurring disorders such as alcohol or substance abuse.

67. www.nycourts.gov/courts/problem_solving/mh/home.shtml [accessed 09/06/2012].



NYSDA's President, Edward J. Nowak (r), and Public Defense Investigation Support Project Director John Cutro (c), accept a $5,000 grant awarded by the New York Bar Foundation; the check was presented by the Chair of the Fellows of the Bar Foundation, Jim Ayers (l), during the April 26 NYSDA Board Meeting.



Cake! The Backup Center's staff celebrated the latest installation of the Public Defense Case Management System in March; that installation brought the number of offices using PDCMS to 50.