

New York Reforms Its System of Protection for Vulnerable Individuals

By Jennifer Monthie

New York State's system for protecting its most vulnerable citizens has been publicly attacked over the last year. The abuse and neglect of vulnerable New Yorkers, particularly individuals with developmental disabilities, has called into question the state's ability to protect individuals within its care. This criticism has fueled the state to re-examine the entire system of care for people with disabilities, hold public hearings exploring abuse and neglect, and pursue extensive legislative reform. This is not the first time in New York's history that public criticism has resulted in the state making major reform to its system of care for individuals with disabilities. In fact, New York's current model was created after public exposure of abusive and neglectful conditions at the state's facilities for individuals with developmental disabilities.



The History of Abuse and Neglect in New York—The Formation of the Current System

In the 1970s Congress drew public attention to the care of individuals with disabilities through a series of public hearings and launched a federal response to abuse and neglect of individuals with disabilities.¹ Among the original catalyst for reform for abuse and neglect were the horrible conditions at a New York State facility located in Staten Island, Willowbrook State School. Willowbrook, a state-operated facility for children with intellectual and developmental disabilities, became known to the public when its atrocities and abuses were exposed in a 1972 news report by journalist Geraldo Rivera.² The infamous and horrifying stories that came out of the Willowbrook scandal focused public outrage on New York State's system of care for individuals with disabilities. A series of governmental investigations revealed deplorable conditions at the facility, including severe overcrowding, unsanitary facilities, and physical and sexual abuses of residents by employees of the facility.³ One report to Congress described over 200 children crammed into a single room with three to four staff, covered with their own feces, naked or in rags, and banging their heads against the wall.⁴ Unfortunately, the conditions of Willowbrook were alarmingly common in facilities around the United States.⁵ Then newly elected Governor Hugh Carey called the terrible conditions at Willowbrook unworthy of New York State and embarked on a process of overhauling the state's system of care to individuals with disabilities.⁶

In 1977, New York State dismantled the state agency that delivered services to individuals with disabilities, the Department of Mental Hygiene, and created three separate state agencies to serve New Yorkers with disabilities: The Office of Mental Health (OMH); the Office of Mental Retardation and Developmental Disabilities later renamed the Office for People with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS).⁷ These three state agencies still serve New Yorkers with disabilities today.

The legislation also created the Commission on Quality of Care, later renamed the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC-APD).⁸ CQC-APD was charged with the responsibility to provide independent oversight of the three state agencies, "for the purpose of offering the Governor and Legislature...informed, yet impartial, advice and recommendations to ensure that service recipients receive the highest quality of care."⁹

The federal government also took action to address the abuse and neglect of vulnerable individuals with disabilities by enacting the Developmental Disabilities and Bill of Rights Act ("DD Act") for citizens with developmental disabilities.¹⁰ The DD Act enumerated a "Bill of Rights" for individuals with intellectual and developmental disabilities living in residential facilities including: appropriate treatment and services, appropriate medical and dental care, limitations on the use of physical restraint, prohibition of the excessive use of chemical restraint, and permission to close relatives to visit their loved ones without notice.¹¹ To ensure the protections of individuals with disabilities receiving state services, the federal government required that each state create a Protection and Advocacy (P&A) agency to "pursue legal, administrative and other appropriate remedies to ensure the protection of the rights of people with disabilities."¹² In 1980, CQC-APD was designated as New York State's federal P&A agency and continues to serve in this role today.¹³

New York Times Series "Abused and Used"

In 2011, New York State's system of care for individuals with disabilities once again came under public scrutiny with the publication of a series of articles led by the *New York Times*. The *Times* articles reported repeated and widespread abuse and neglect of individuals with developmental disabilities in programs operated or licensed by the Office for People With Developmental Disabilities (OPWDD).¹⁴ The series highlighted Jonathan Carey, a 13-year-old child with autism and a repeated victim of abuse and neglect.¹⁵ Jonathan was slowly crushed to

death in the back seat of a state-operated van by an employee of the OPWDD.¹⁶ The state employee who crushed Jonathan was later convicted of negligent homicide; the state also settled with the family civil suit for \$5 million.¹⁷ The *Times*' report exposed the care of Jonathan prior to his death and reported that he sustained numerous unexplained injuries including a black eye and a broken nose in less than 18 months at the state institution.¹⁸

The *Times*' investigation revealed that the tragic death of Jonathan Carey was not an isolated incident and published a series of articles exposing systemic concern with the state's system of care.¹⁹ In 2009, OPWDD alone received 13,000 allegations of abuse in state-operated and licensed facilities but less than 5 percent were referred to law enforcement.²⁰ Furthermore, only 30 out of the 233 workers involved in these allegations were successfully terminated from employment, and in 25 percent of the cases the employee was transferred to another home serving individuals with disabilities.²¹ In 2010, OPWDD only reported roughly 47 percent of the allegations of physical abuse to law enforcement, and 25 percent of sexual abuse of individuals with developmental disabilities at group homes and institutions in New York State were never reported to law enforcement authorities.²² The *Times* articles prompted state and federal reviews of New York's current system and its failure to protect individuals with disabilities from abuse and neglect.

The State Examines Its Care of Individuals with Disabilities

As an example of how history often repeats itself, New York State's response to the public outcry of abuse and neglect resembled the prior action it took over 30 years prior—leaders examined the concerns through public comment/hearings, and the state engaged in legislative reform of the system.

Governor Andrew M. Cuomo called the state's response to abuse and neglect allegations alarming and vowed to reform the state agencies that provide residential care to individuals with disabilities, the elderly, and children.²³ A new position, Special Advisor to the Governor for Vulnerable Persons, was created and Clarence Sundram was appointed to this position in March 2011 to "assist Governor Cuomo in strengthening the state's system of protection and safety for vulnerable New Yorkers in residential care setting."²⁴ Mr. Sundram was responsible for broadly evaluating the state's system and providing recommendations concerning the state's programs related to developmental disabilities, mental health, alcohol and substance abuse, children, and the elderly.²⁵

In April 2012, Mr. Sundram released a report, "The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect," to address problems of abuse and neglect of vulnerable people in residential programs operated or supported by

agencies of the state of New York.²⁶ The report exposed "gaps and inconsistencies" within the six state agencies that serve vulnerable New Yorkers, including formidable barriers to reporting abuse and neglect by direct support staff and residents; poor articulation of "zero tolerance" policies; ineffective investigations of abuse and neglect; unsuccessful disciplinary actions against employees who abuse and neglect; and variations in the rate of reporting between different types of residential programs.²⁷

The report attempts to answer questions about why the system of reporting and investigating incidents of abuse and neglect is not protecting the vulnerable in New York.²⁸ An examination of the legal framework of the state agencies that serve vulnerable persons shows that each of the state agencies differ significantly in reporting, investigating, and defining abuse and neglect.²⁹ For example, Office of Mental Health (OMH) defines abuse as "any of the following acts by an *employee*: improper medication administration, physical abuse, psychological abuse, sexual abuse."³⁰ The Office of Alcohol and Substance Abuse Services (OASAS) defines abuse as "maltreatment of a person that would endanger the physical or emotional well-being of such person through the action or inaction on the part of *anyone*."³¹ An examination of these two definitions shows that OMH focuses on employee-only conduct while OASAS includes investigations by anyone coming into contact with a person within its care.

Further discrepancies can be found in the type of conduct that will constitute abuse. For example, OPWDD has the broadest definition of physical abuse which includes "physical contact which is not necessary for the safety of the person and/or *causes discomfort* to the person ... [or] the handling of a person with more force than is reasonably necessary."³² In contrast, the Department of Health (DOH) defines physical abuse as "inappropriate physical contact which *harms or is likely to harm* the patient."³³ These two regulations both define physical abuse as hitting, pinching, kicking, and shoving, but differ in determining what other conduct may be considered physical abuse—OPWDD uses the "causes discomfort" standard and DOH uses the "harms or is likely to harm" standard.

Furthermore, each state agency has different standards for who investigates the reported abuse and neglect, the training requirements for these investigators; the standard of proof used in the investigation; the requirements for reporting possible crimes to law enforcement; and the requirement to report to external oversight entities.³⁴

These inconsistencies between state agency definitions and reporting requirements are especially problematic to providers who operate programs that are licensed or certified by more than one state agency. Mr. Sundram's report found 112 agencies that were issued operating certificates to provide residential/inpatient care by multiple state agencies.³⁵ The children and adolescents residential programs are often licensed or certified by more than

one state agency.³⁶ In fact “[a]t least 14 agencies serving children have multiple certified programs located on the same campus, often just yards apart from each other, thus exacerbating problems for staff who must adhere to varying standards as residents mingle during campus activities and programs.”³⁷

The report identifies several other concerns with the existing system including: the lack of consistent requirement to maintain a registry of prior abusers, no mandate to conduct trend analysis of incidents of abuse and neglect, and no universal requirement to report to external parties with oversight/investigatory powers.³⁸ Mr. Sundram’s report recommends comprehensive reform to the way New York State investigates, documents, and responds to incidents of abuse and neglect within New York State’s system of care. This reform includes: (1) adopting a common set of definitions for abuse and neglect so that no matter which system serves an individual there is a universal definition; (2) implementing one statewide, centralized, 24-hour staffed hotline for reporting abuse and neglect of vulnerable persons; (3) establishing an entity with the authority to investigate and prosecute all offenders who abuse and neglect vulnerable individuals within the state’s system of care; (4) instituting common standards for investigations and requiring the use of trained investigators; (5) creating standards that differentiate between treatment of serious and repeated acts of abuse and neglect and lesser offenses and incidents that are caused or contributed to by workplace conditions; (6) creating one interagency Statewide Central Register for all abuse and neglect of vulnerable persons so that offenders do not shuffle from one system to another; and (7) giving responsibility of oversight and monitoring of all state-licensed or operated programs to one entity.³⁹ To accomplish this reform the report calls for the enactment of legislation to protect vulnerable children and adults.⁴⁰

The New York Assembly also responded to public scrutiny of the system and held public hearings⁴¹ in June 2011 aimed at “carefully examining the quality of care and safety measures in homes for individuals with developmental disabilities.”⁴² The hearings exposed the same problems with the state’s system of investigating abuse and neglect: lack of reporting to law enforcement, lack of transparency, retention of workers who commit physical and sexual abuse, and the state’s inadequate oversight structure.⁴³ These hearings also revealed that each state agency had a different threshold for categorizing conduct as abuse or neglect, and different procedures for reporting, investigating, and confirming the existence of abuse or neglect.⁴⁴

Federal Auditors Expose Problems in New York’s Protection and Advocacy System

In July of 2011, New York’s federally funded Protection and Advocacy (P&A) system also received scrutiny when it underwent a review from the U.S. Department of

Health & Human Services, Administration on Developmental Disabilities (ADD). The federal P&A system was created to provide federal oversight of each state’s systems of care for persons with disabilities.⁴⁵ Under federal law, each state’s governor designates a single state or non-profit agency to serve as the state’s P&A.⁴⁶ The designated P&A must administer each of the seven P&A programs.⁴⁷

ADD conducted on-site review of New York’s designated P&A agency CQC-APD. ADD is responsible for ensuring that a state’s P&A agency is meeting the federal programs requirements of improving the lives of people with disabilities and their families. ADD was particularly “interested in knowing the extent to which the Agency [CQC-APD] has the authority and independence to carry the function of the P&A.”⁴⁸

CQC-APD administers the P&A program by contracting with nine not-for-profit law offices and two law schools.⁴⁹ In December 2011, ADD issued notice to CQC that it was out of compliance with several requirements of the federal P&A program, including a lack of independence from other state agencies that provide treatment and services to individuals with developmental disabilities. The federal audit found that,

gubernatorial appointment of Chair and Commissioners [of state agencies including CQC-APD] and the influence of the political structure (due to staff reporting lines) call into question the independence of [CQC-APD]. The reporting structure does not support the NY P&A’s independence and objectivity that is also responsible for directing [other state] agencies providing treatment and service to individuals with developmental disabilities, including the Director of the Office of People with Developmental Disabilities.⁵⁰

ADD required CQC-APD to respond with a corrective action plan to ensure that New York’s P&A was taking proper steps to comply with federal program requirements.⁵¹

CQC-APD conducted an internal review of its system and responded by holding three public hearings to obtain comment from current or former clients of the P&A system, advocates, stakeholders, and other individuals interested in the P&A system.⁵² The public hearings addressed whether New York should operate its P&A system through a not-for-profit or maintain its current structure through CQC-APD.⁵³ In April 2012, following this public comment period, CQC-APD issued a report to Governor Cuomo recommending that the agency turn over the federally funded and mandated P&A function to an independent not-for-profit agency to be chosen by the Governor.⁵⁴ CQC-APD found that most other states designated not-for-profit agencies as the P&A operator for the state and “the most common reason has been to ensure the independence and autonomy of the P&A.”⁵⁵ It

also concludes that because CQC-APD is a state agency, controlled by the governor, it “cannot bring litigation or engage in independent legislative advocacy, two core activities of the federal P&A system.”⁵⁶ To improve New York’s P&A system, CQC-APD recommended that the Governor designate a nonprofit organization to serve as the P&A agency in New York.⁵⁷

New York State Redefines the System

On May 7, 2012, after receiving the reports from Mr. Bearden, Chair of CQC-APD, and Mr. Sundram, Special Advisor to the Governor on Vulnerable Persons, Governor Cuomo announced reforms to the state’s system of protecting vulnerable New Yorkers. The Governor unveiled legislation to create a Justice Center for the Protection of People with Special Needs which would direct how the State protects New Yorkers in State operated, certified, or licensed facilities and programs.⁵⁸ “The Justice Center would have a Special Prosecutor and Inspector General... who will investigate reports of abuse and neglect and prosecute allegations that rise to the level of criminal offenses.”⁵⁹ The Justice Center would also operate a 24/7 hotline, a statewide database that will track all reports of abuse and neglect, and a statewide register of workers who have committed serious acts of abuse who will be prohibited from ever working with people with disabilities or special needs.⁶⁰ The legislation mirrored many of the suggestions from Mr. Sundram’s report “The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect.”

The legislation was introduced in the New York State Senate (Senate Bill 07400) on May 8, 2012 and passed the Senate on May 16, 2012.⁶¹ However, the legislation stalled in the New York State Assembly. On June 17, 2012, four days before the end of the legislative session, Governor Cuomo, Senate Majority Leader Dean Skelos, and Assembly Speaker Sheldon Silver announced an agreement on legislation to reform New York State’s system of oversight.⁶² The legislation was voted on and unanimously passed both houses of the Legislature.⁶³

The agreed-upon legislation was similar to the original measure proposed by the Governor in that it creates a Justice Center for the Protection of People with Special Needs which will have a Special Prosecutor and Inspector General to investigate reports of abuse and neglect and prosecute allegations that rise to the level of criminal offenses.⁶⁴ The revised legislation included additional provisions not in the Governor’s proposal, such as a new Advisory Council, composed of at least 15 members, to provide guidance to the Justice Center in the development of programs, policies and regulations.⁶⁵ Members of the group will include individuals with experience in the care of persons with disabilities and individuals or family members of individuals who participated in state mental health programs.⁶⁶ The legislation also requires the Gov-

ernor to appoint a not-for-profit agency to serve as New York’s federal Protection and Advocacy agency, removing this function from the state.⁶⁷

The Justice Center will be primarily responsible for tracking, investigating, and pursuing serious abuse and neglect complaints for operated, certified, or licensed entities within the six state agencies: Department of Health (DOH), OMH, OPWDD, Office of Children and Family Services (OCFS), OASAS, and the State Education Department (SED).⁶⁸ The legislation also creates a 24/7 hotline to receive complaints of abuse and neglect to investigate and/or refer to law enforcement; develops a register of workers who have committed serious or repeated acts of abuse; represents the state in all public employee disciplinary cases or those where the state is seeking termination; develops common standards for investigations and requires the use of trained investigators; consolidates background checking, including review of criminal history for any employee, volunteer, or consultant at any facility or provider agency operated, licensed or certified by OMH, OPWDD, and OCFS.⁶⁹ The legislation also eliminates CQC-APD and transfers all the powers and authority of CQC-APD, other than the federal Protection and Advocacy function, to the newly created Justice Center. The federally funded Protection and Advocacy program will be designated to an independent not-for-profit agency in New York State.⁷⁰

New Yorkers Wait for Reform

Over the last year, New York’s system of care for individuals with disabilities has been heavily criticized for its inability to protect the individuals it serves. The state responded, as it did 30 years ago, with the creation of a new state agency to provide oversight of the care to individuals with disabilities. Over the next year, proponents and critics will be watching to see the impact of this legislation and whether the new system, both public and not-for-profit, will be more effective at addressing the abuse and neglect of citizens within New York State’s care.

Endnotes

1. *Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973: Hearing on S. 427 and S. 458 Before the Subcomm. on the Handicapped of the S. Comm. on Labor & Public Welfare, 93d Cong. 562 (1973)* [hereinafter *Developmental Disabilities Act 1973 Hearing*].
2. S. REP. NO. 94-160, at 29 (1975).
3. S. REP. NO. 93-1169, at 33 (1973).
4. *Developmental Disabilities Act 1973 Hearing, supra* note 1 (statement of Geraldo Rivera).
5. In 1973, Congress described these public institutions as
hopeless places dedicated to custodial care of lifelong residents. All too often these institutions are far removed from urban areas and represent an effort of society to forget its obligations to their residents... these circumstances tend to generate environments in which residents can be neglected and even abused,

and which unfortunately often lead to deterioration of the residents' physical and mental condition.

S. REP. NO. 93-1169, at 29–30.

6. N.Y. STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, IMPROVING LIVES, PROTECTING RIGHTS: KEEPING THE DREAM ALIVE i (2002–2003), <http://cqc.ny.gov/uploads/Publications/ar0203.pdf> [hereinafter *Improving Lives*].
7. *Id.*
8. *See id.*
9. *Id.*
10. These rights were later extended to individuals with other disabilities, including mental illness, with the passage of the federal Protection and Advocacy for Individuals with Mental Illness Act of 1986. 42 U.S.C. § 10801.
11. Pub. L. No. 94-103, § 201; 89 Stat. 426 (codified as 42 U.S.C. § 15009). The Supreme Court later ruled that there was no individual right of action against states for failure to comply with the Bill of Rights provisions of this Act. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981).
12. Pub. L. No. 94-103, § 203, 89 Stat. 426, 504 (codified as 42 U.S.C. § 15043).
13. *Improving Lives*, *supra* note 6, at 1.
14. Danny Hakim, *At State-Run Homes, Abuse and Impunity*, N.Y. TIMES, Mar. 13, 2011, at A1 [hereinafter *At State-Run Homes*].
15. Danny Hakim, *A Disabled Boy's Death, and a System in Disarray*, N.Y. TIMES, June 6, 2011, at A1 [hereinafter *A Disabled Boy's Death*].
16. *Id.*
17. Danny Hakim, *\$5 Million Payment to End Suits Over Death of 13-Year-Old Boy in State Care*, N.Y. TIMES, Sept. 22, 2011, at A25.
18. *A Disabled Boy's Death*, *supra* note 15.
19. *See At State-Run Homes*, *supra* note 14; Russ Buettner, *For Disabled Man Left in Van, Cause of Death is Unclear*, N.Y. TIMES, Aug. 4, 2011, at A22; Danny Hakim, *For Disabled Care Complaints, Vow of Anonymity Was False*, N.Y. TIMES, Nov. 12, 2011, at A1; Danny Hakim & Russ Buettner, *In State Care, 1200 Deaths and Few Answers*, N.Y. TIMES, Nov. 6, 2011, at A1; Danny Hakim, *In Treating Disabled, Potent Drugs and Few Rules*, N.Y. TIMES, Dec. 23, 2011, A1; Russ Buettner, *An Operator of Group Homes Keeps State Aid Despite Faults*, N.Y. TIMES, Dec. 28, 2011, A1.
20. *At State-Run Homes*, *supra* note 14.
21. *Id.*
22. Danny Hakim, *Progress Claimed in Reporting Abuse at Group Homes*, N.Y. TIMES, June 14, 2011, at A17 [hereinafter *Progress Claimed in Reporting*].
23. Danny Hakim, *Cuomo Vows Reform at Residential Care Agencies*, N.Y. TIMES, Oct. 12, 2011.
24. *The Governor's Special Advisor on Vulnerable Persons: A Message from Clarence J. Sundram*, N.Y. State Governor, <<http://www.governor.ny.gov/advisorvulnerablepersons>> (last visited Oct. 16, 2012).
25. *Id.*
26. Clarence J. Sundram, *The Measure of a Society: Protection of Vulnerable Persons in Residential Facilities Against Abuse & Neglect* (2012), <<http://www.governor.ny.gov/assets/documents/justice4specialneeds.pdf>>.
27. *Id.* at 6.
28. *See generally id.*
29. *Id.* at 22–28.
30. 14 N.Y. Comp. Codes R. & Regs. § 524.4 (N.Y.C.R.R.) (emphasis added).
31. 14 N.Y.C.R.R. § 836.4 (emphasis added).
32. 14 N.Y.R.C.C. § 624.4 (emphasis added).
33. 10 N.Y.R.C.C. § 81.1 (emphasis added).
34. Sundram, *supra* note 26, at 22–29.
35. *Id.* at 31.
36. *Id.*
37. *Id.*
38. *Id.* at 27–30.
39. *Id.* at 65–78.
40. *Id.* at 66.
41. Public Hearings were held by Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities (Chaired by Assemblyman Felix Ortiz); the Committee on Codes (Chaired by Assemblyman Joseph Lentol); and the Committee on Oversight, Analysis and Investigation (Chaired by Assemblyman Jonathan Bing).
42. Press Release, New York State Assembly, News Release, Assembly Speaker Sheldon Silver (May 27, 2011) (on file with author); Letter from Sheldon Silver, Speaker N.Y. State Assembly, to Felix Ortiz, Chair Comm. on Mental Health, Mental Retardation & Developmental Disabilities, Joseph Lentol, Chair Comm. on Codes, & Jonathan Bing, Chair Comm. on Oversight, Analysis and Investigation (Mar. 25, 2011), <<http://assembly.state.ny.us/Press/20110525a/letter.pdf>>.
43. *Progress Claimed in Reporting*, *supra* note 22.
44. *Id.*
45. Roger Bearden, Report on the Administration of the Protection and Advocacy and Client Assistance Program (2012) (on file with author).
46. Protection and Advocacy for Persons with Developmental Disabilities, 42 U.S.C. § 15041 et seq., 45 C.F.R. § 1386.1 et seq.; Protection and Advocacy for Individuals with Mental Illness, 42 U.S.C. § 10801 et seq., 42 C.F.R. § 51.1 et seq.; Protection and Advocacy for Individual Rights, 29 U.S.C. § 794e, 34 C.F.R. § 381.1 et seq.; Protection and Advocacy for Assistive Technology, 29 U.S.C. § 3004; Protection and Advocacy Beneficiaries of Social Security, 42 U.S.C. § 1320b-21; Protection and Advocacy for Individuals with Traumatic Brain Injury, 42 U.S.C. § 300d-53; Protection and Advocacy for Voting Accessibility, 42 U.S.C. § 15461. The federal government has also established the Client Assistance Program (CAP) to assist individuals with disabilities in accessing vocational rehabilitation services. Client Assistance Program, 29 U.S.C. § 732, 34 C.F.R. § 370.1 et seq.
47. The P&A program consists of seven programs: Protection and Advocacy for Persons with Developmental Disabilities; Protection and Advocacy for Individuals with Mental Illness; Protection and Advocacy for Individual Rights; Protection and Advocacy for Assistive Technology; Protection and Advocacy for Beneficiaries of Social Security; Protection and Advocacy for Individuals with Traumatic Brain Injury; and Protection and Advocacy for Voting Accessibility. *Id.* at 1.
48. Letter from Sharon B. Lewis, Comm'r Admin. of Developmental Disabilities, to Roger Bearden, Chair Comm'n on Quality of Care and Advocacy for Persons with Disabilities (Dec. 13, 2011) (on file with author) [hereinafter *Letter from Sharon B. Lewis*].
49. New York Lawyers for the Public Interest; Legal Services of Central New York; Disability Advocates, Inc.; Neighborhood Legal Services, Inc.; Nassau/Suffolk Law Services; Legal Services of the Hudson Valley; Albany Law School; Legal Aid Society of Northeastern New York; Western New York Advocacy for the Developmentally Disabled; Long Island Advocacy Center; and Touro College of Law. CQC-APD administers the Client Assistance Program through its contracts with Western NY Independent Living; Regional Center for Independent Living; Westchester Independent Living Center; Capital District Center for

Independence; Long Island Advocacy Center; Resource Center for Independent Living; Catskill Center for Independence; and Center for the Independence of the Disabled NY. Bearden, *supra* note 45, at 3-4.

50. Letter from Sharon B. Lewis, *supra* note 48.
51. *Id.*
52. Press Release, N.Y. State Comm'n on Quality of Care and Advocacy for Persons with Disabilities, Notice of Public Forums (Jan. 10, 2012) (on file with author).
53. *Id.*
54. Bearden, *supra* note 45, at 10.
55. *Id.* at 8.
56. *Id.* at i.
57. *Id.* at 10.
58. Press Release, Andrew M. Cuomo, Governor Cuomo Announces First in the Nation Reforms to Protect People with Special Needs and Disabilities (May 7, 2012) (on file with author).
59. *Id.*
60. *Id.*
61. S.07400, 2012 N.Y. Leg Sess.
62. Press Release, Andrew M. Cuomo, Governor Cuomo and Legislative Leaders Announce Agreement on Legislation to Protect People with Special Needs and Disabilities (June 17, 2012) (on file with author).
63. A.10721, 2012 N.Y. Leg Sess.; S.07749, 2012 N.Y. Leg Sess. The bill was signed by the Governor on December 17, 2012. 2012 N.Y. Laws Ch. 501.
64. A.10721, N.Y. Leg Sess.; S.07749, N.Y. Leg Sess.
65. A.10721, N.Y. Leg Sess.; S.07749, N.Y. Leg Sess.

66. A.10721, N.Y. Leg Sess.; S.07749, N.Y. Leg Sess.
67. A.10721, N.Y. Leg Sess.; S.07749, N.Y. Leg Sess.
68. A.10721, N.Y. Leg Sess.; S.07749, N.Y. Leg Sess.
69. A.10721, N.Y. Leg Sess.; S.07749, N.Y. Leg Sess.
70. Roger Bearden, Commission on Quality of Care and Advocacy for Persons with Disabilities Solicitation of Interest (2012), <<http://cqc.ny.gov/uploads/SOI/CQCSOI.pdf>>.

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