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Message from the Outgoing Chair

Martin Hersh

My term as Chair of our Section ended on May 31, 2018. I will be forever grateful for all the support given to me by my fellow officers, program chairs, committee chairs and committee members, and the membership in general. Without this support my job would have been significantly more difficult, especially being that I am a solo practitioner. My job is not yet done. As Immediate Past Chair, I will work with former chair **David Goldfarb** to help formulate our Section's CLE programs. I also will be chairing the Nominating Committee, so if any of you have any thoughts for future CLE programs and/or suggestions for future officers or District Delegates of our Section's, please let me know.

On February 28, 2018 our Lobby Day team of **Rene Reixach**, **Rick Marchese**, **Tara Pleat**, **Deep Mukerji**, **Jeff Asher**, **Matt Nolfo**, **David Kronenberg**, **David Goldfarb**, **Chris Bray**, **Val Bogart**, **Betsy Klampert**, and myself went to Albany to lobby against several budget bill items proposed by Governor Cuomo. We successfully fended off the Governor's attempt to eliminate spousal refusal for community Medicaid, the drastic lowering of the CSRA from $74,820 to the minimum of $24,180, and the requirement of having a score of 9 on the Uniform Assessment System assessment tool to participate in an MLTC program. I want to thank each of our Lobby Day team members for taking the time to travel to Albany and help us defeat these proposals.

Financially speaking, and thanks largely to our Sponsorship Committee consisting of **Elizabeth Briand** and **Lauren Sharkey**, we are exceeding expectations. Comparing the March 2017 and 2018 financials, we were able to add over $50,000 to our surplus! NYSBA policy mandates that our surplus, which comes, mostly, from the profit that our Spring, Summer and Fall meetings generate, must be used in areas that benefit our Section's membership as a whole. We have tried to and will continue to use some of our surplus on diversity initiatives, member retention, and new member recruitment. I and my fellow Officers welcome any ideas from you on how we can spend this surplus.

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Message from the Incoming Chair

Judith D. Grimaldi

It is with great anticipation that I write my first message as Chair of the Elder Law and Special Needs Section (ELSN).

I am so proud to have this opportunity to continue the work of so many colleagues in the Elder Law and Special Needs Section whom I admire. It will be a challenge to step into their shoes. Our work as elder law and special needs attorneys has become more challenging as the basic societal supports on which our clients thrive can no longer be taken as a given. Foundational programs such as Social Security, Medicare and certainly Medicaid and disability services are being re-examined, re-designed and often reduced. Social Security has been re-characterized from a contributory social insurance program to an entitlement that can be altered and changed. Thus, the rules of the game are changing in the middle of the game and our clients are caught in the mix. The elder law and special needs attorney's role as advocate and advisor is becoming even more crucial. We are asked by our clients to maximize their planning options, create defensive strategies, and help them understand the impact of these changes on them, their finances and their family.

Our law practices are now operating in an intensively competitive environment as other types of advisors vie for the attention of the retirees and baby boomers. We must offer cutting edge legal services, and financial and tax strategies, while integrating technology, marketing, sales, and cultural competency into our daily practice. The elder law and special needs attorney has become the lawyer for the later years, which requires we have the knowledge to cover life from pre-retirement to death. The elder's expansive life cycle requires we know long-term care and estate planning, but we now must also know about health, housing, financial security, community resources, treatment of Alzheimer's and other chronic diseases, government benefits beyond Medicare and Medicaid, real estate, retirement savings and tax implications. The list continues to grow as the elders and the families we serve

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Our UnProgram was held at the Desmond in Albany this past spring. It was a terrific success. I wish to thank both Shari Hubner and Antony Eminowicz for their tireless efforts in organizing the event, and to Lisa Bataille, who kept the program running smoothly. I met some great young and new members to our Section. I am confident that some of these new members will become active in our Section and add to its vitality.

I mentioned this previously in one of my prior messages, but it is vital to the health of our Section that we reach out for new and younger members to become involved with our Section, as this adds to the value and vitality that new members provide. New Section members offer new ideas, input and participation, and this will only help strengthen our Section and help us meet the challenges ahead. I, again, ask each of you to reach out to colleagues and espouse the values of membership in our Section. If each of us can bring in just one new Section member, we'd become one of the largest Sections in NYSBA, and a better Section for it.

If any of our younger members want to become more involved with Section membership, such as writing an article for our *Journal*, organizing a district event or help in choosing a committee to join, please reach out to either Lauren Sharkey (LSharkey@cswlawfirm.com) or Katie Carpenter (kcarpenter@wplawny.com) who are the Young Lawyer Engagement sub-committee co-chairs.

Judith Grimaldi is now Chair, with Chair-elect Tara Pleat, Vice-Chair Matt Nolfo, Secretary Deepak Mukerji, and Christopher Bray Treasurer. During my term each have demonstrated their leadership skills and devotion to the practice of Elder Law and Special Needs. Our Section is in good hands and will be for years to come. I wish to thank them all, as well as our NYSBA staff liaison, Lisa Bataille, whose knowledge and organization have helped me during my tenure.

I thank all of you for your assistance and support during my term as Chair.

Martin Hersh

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are becoming more diverse…culturally, ethnically, socially, financially and geographically. This is what makes the practice interesting and exciting, and each day presents a new issue and a new challenge.

I am hopeful that during my year as Chair of the Section together we will meet these challenges with wisdom, energy and grace. Government benefits, including Medicaid, Section 8 housing, and SNAP, are facing cuts and limits on eligibility. We must be alert to these changes happening in other states already through federally encouraged Medicaid waivers, which are not aimed at improving services but shrinking them. Work requirements for recipients of Medicaid, Section 8 and SNAP are being imposed in several states. We in New York need to be on guard against these types of changes slipping into our state plan as the state deals with reduced federal support. We face an uphill battle in this area. It will take all of our focuses to hold the line on services for the elderly and disabled communities. I ask for your support as we are an important voice for our clients' interests in New York State and in Washington.

I will be proud to work together with my fellow officers: Tara Anne Pleat, Chair-elect; Matt Nolfo, Vice-Chair; Deepankar Mukerji, Secretary, and Christopher Bray, Treasurer.

On these issues, our Section and the Medicaid Committee will continue to work with the non-profit and legal services community to advocate for improvements in the delivery of home and community-based services throughout the state. The conversion of Medicaid home care to a managed care system under the MLTC program has proven to be a roller coaster ride. The financing of the program has disadvantaged the chronically ill elder who needs extensive care to remain safely at home and avoid institutionalization. The unrealistic capitated rate and

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the rising labor costs of the personal care aide has undermined the viability of the safe home, which has been New York's tradition. The Medicaid committee will be continuing their efforts to offer alternatives and solutions to make the MLTC program function more optimally for our clients and their families.

Our Section will continue to advocate for a revised Power of Attorney law and will continue to cooperate with the other NYSBA Sections on producing workable legislation. The Client and Consumer Issues Committee have completed the LegalEase pamphlets which are now available for all Section members to use in their practice. The Mediation Committee has moved its project along and is actively working in Nassau, Queens and the Capital District to use mediation as an alternative to litigation in estate and guardianship cases.

We had an extremely successful Summer Meeting at the Queens Landing in Niagara-on-the-Lake in Canada on July 12-14, ably chaired by JulieAnn Calareso and Beth Polner Abrahams. They organized the meeting with two tracks for either beginners and more advanced practitioners. Newly admitted attorneys were able to receive credits for their participation in the meeting. The program also took advantage of the beautiful location near Niagara Falls, the wineries in the region and the world renowned Shaw Theater festival.

The Fall Meeting will be held on October 4th and 5th at the Park Ridge Marriott in Northern New Jersey, right in time to see the autumn leaves spectacular. Chairs Mary Fern Breheney and Moriah Adamo are working on the program and have chosen the theme, "The New Economics of Aging…How to Adapt the Elder Law Practices to It." They have invited a renowned labor economist who focuses on income security and financing life in the retirement years. Hope to see you there.

I look forward to this upcoming year in the Elder Law and Special Needs Section and, most importantly, to working with each one of you.

Judith D. Grimaldi

The Section's District Leaders

County (District)	District Leader	Firm
White Plains (1st)	**Elizabeth Valentin**	Littman Krooks LLP
Brooklyn (2nd)	**Yana Feldman**	Yana Feldman & Associates, PLLC
Kingston (3rd)	**Antony M. Eminowicz**	The Law Office of Antony M. Eminowicz, Esq.
Clifton Park (4th)	**Katherine Carpenter**	Wilcenski & Pleat PLLC
Syracuse (5th)	**Christine Woodcock Dettor**	Bousquet Holstein PLLC
Endicott (6th)	**Karen Jean McMullen**	Levene Gouldin & Thompson, LLP
Rochester (7th)	**Richard A. Marchese, Jr.**	Woods Oviatt Gilman LLP
Buffalo (8th)	**Laurie L. Menzies**	Pfalzgraf Beinhauer & Menzies LLP
Westchester (9th)	**Sara Meyers**	Enea, Scanlan & Sirignano, LLP
Smithtown (10th)	**Jeanette Grabie**	Grabie & Grabie, LLP
New York City (11th)	**David Ian Kronenberg**	Goldfarb Abrandt Salzman & Kutzin, LLP
Bronx (12th)	**Malya E. Levin**	The Weinberg Center for Elder Abuse Prevention at the Hebrew Home at Riverdale
Staten Island (13th)	**Anthony S. Danna** **Anthony J. Lamberti**	Danna & Associates, PC Armstrong & Lamberti, PLLC

Message from the Co-Editors-in-Chief

With the Summer 2018 *Journal*, our tenure as co-editors of the *Elder and Special Needs Law Journal* has ended. We felt it would be a fitting (and fun) end to be interviewed ourselves! We have greatly enjoyed our work on the *Journal*, and while always on time we have pursued relevant, thoughtful and new content for our Section. The Summer *Journal* is no different, and we hope you enjoy this edition and our interview.

Judith Nolfo

Our resident interview specialist (and new co-editor), Katherine Carpenter, helped us with our final piece for the *Journal*!

Enjoy!

Q Where are you from?

JUDY: Kingston, the first capital of New York.

TARA: The second capital of New York, Albany.

Q What do you like about the area and community?

TARA: I love that I am in driving distance to hiking in the Adirondacks.

JUDY: I love exploring the Hudson Valley and Woodstock when I am in Kingston. Albany has great people and awesome restaurants.

Q What is the most memorable and favorite place you have traveled to?

TARA: Edinburgh, Scotland. I went when I was a first-year in law school and I can't wait to go back!

JUDY: The Seven Sacred Pools in Maui, also known as Ohe'o Gulch in Haleakala National Park. The pools are tiered with waterfalls above, each flowing into the next below. The water is aerated, rumored to restore strength and vitality. I never wanted to leave.

Q Tell me about your family/kids.

TARA: I have two children, Drew and Sophia. Drew is 14 and is a Godzilla and Star Wars enthusiast. This summer we left the Summer Meeting a day early to go to the 25th Annual G-Fest, a Godzilla convention in Chicago. Drew is also a budding artist. A painting he did in a program for children on the Autism Spectrum graces the recently completed ELSN Section Guide. Sophia is 13 and entering eighth grade. She keeps us hopping with her travel softball schedule. She plays right field and first base for the Saratoga Thunder 05 travel team. Our family loves to hike, and while free time is at a premium, that's what we do when we can.

Tara Anne Pleat

JUDY: I have two daughters. Lia is 21 and a junior in college, and Ali, who is 18 and a senior in high school. I am mad about my rescue dog, Layla, who is a lab/beagle/border collie mix. I grew up with a wonderful family—my parents, Jake and Mary Eileen, and my brother, Matt, and his amazing family.

Q What's your favorite part about your job?

JUDY: The people! I love to meet new people and represent them—there are amazing stories that I encounter working with people carrying huge burdens and you would never know. It's very humbling and keeps me grateful for all I have.

TARA: Sharing personal experiences and meaningful guidance to the families and individuals we represent. Being the mother of a child who has special needs together with other personal experiences with incapacity and loss has helped me become a better advocate.

Q What led you to a career in law?

TARA: I was a paralegal in Albany for two years and I quickly realized that I enjoyed working with families and wanted to take it to the next level.

JUDY: I was an accountant and I hated it. Matt was already in law school at Fordham, so my dad thought it was also a good idea for me. Very glad I listened.

Q Tell me about a project or accomplishment that you consider to be the most significant in your career.

TARA: I am very proud to be in partnership with Ed Wilcenski. We have built a wonderful team of attorneys and staff, and I am grateful to be a part of a practice that I love and to work with people who I consider my family.

JUDY: Volunteering with anti-human trafficking organizations to help young women and children.

Q How is it working with each other as editors?

JUDY: I loved it! We are two different persons—she is "type A" and I await instructions, but over the course of three years, I met an amazing friend. We are like Batman and Robin—who adores and worships Batman.

TARA: It was great. Judy is incredibly easy to work with, and often, I am not. I learned so much from her about tolerance and kindness. I couldn't have asked for a better partner.

Q Have you had any turning points in your life?

TARA: When my son was diagnosed, I completely changed my career path. Also, losing a parent—what was always academic became non-academic.

JUDY: When I went off on my own and became a solo practitioner. It was frightening but I've learned to ask questions and easily admit when I do not know or understand something.

Q Where do you see yourself in five years?

TARA: With less on my desk and having completed hiking the summer and winter 46 peaks in the Adirondacks.

JUDY: Living somewhere near the ocean.

Q What did you want to be when you were younger?

TARA: A veterinarian—with a mobile van!

JUDY: An actress and a choreographer on Broadway.

Q Are there hobbies you look forward to on the weekends?

TARA: Hunting, skiing, hiking, biking and golf, depending on the season of course.

JUDY: Weekend trips to Cape Cod. I also read a lot and I enjoy re-reading the classics like Dickens and Austen. I loved the classic law literature like *Orley Farm* by Anthony Trollope, which involved a challenge to a Will.

Q Is there any memorable advice you've been given?

JUDY: My dad always said that life is about offense and defense: keep moving forward and making progress or you will retreat backwards. He was a football coach, if you haven't guessed.

TARA: One of my favorite clients, who passed away some years back, once told me, "It's not enough to be good, you have to do good. And you, Tara, need to keep doing good." While far from perfect, I try to do good whenever and however I can.

Q Is there anything else you want people to know about you?

TARA: I am a nicer person than I often seem. And one thing I want people to know about Judy is that she is the kindest person you will ever meet; we all can learn a lot from her and her belief in every person's genuine goodness. I am grateful for being able to work with her over the last three years.

JUDY: Yes, she's the nicest person I know, very loving, giving and generous with her time and everything else. As for me, I'm a serious foodie.

☐ I am a Section member — please consider me for appointment to committees marked.

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_____

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JOIN A COMMITTEE

Professional Growth Opportunities

Elder Law and Special Needs Section committees address, from the perspective of an elder law practitioner, unique issues facing the elderly, those with disabilities and those in the legal profession. The Section offers you the opportunity to serve on many committees and to network with attorneys throughout the state. Committees give you the opportunity to research issues, influence legislation that affects the elderly and/or those with disabilities, and achieve professional development and recognition.

Elder Law and Special Needs Section Committees

Please designate in order of choice (1, 2, 3) from the list below, a maximum of three committees in which you are interested. You are assured of at least one committee appointment, however, all appointments are made as space availability permits.

___ **Client and Consumer Issues** (ELD4000)
___ **Diversity** (ELD6800)
___ **Elder Abuse** (ELD7600)
___ **Estates, Trusts and Tax Issues** (ELD1200)
___ **Ethics** (ELD7300)
___ **Financial Planning and Investments** (ELD4400)
___ **Guardianship** (ELD1600)
___ **Health Care Issues** (ELD3600)
___ **Legal Education** (ELD1900)
___ **Legislation** (ELD2300)
___ **Mediation** (ELD7400)
___ **Medicaid** (ELD2900)
___ **Membership Services** (ELD1040)
___ **Mental Health Law** (ELD6100)
___ **Mentoring** (ELD7500)
___ **Practice Management** (ELD3300)
___ **Publications** (ELD6600)
___ **Real Estate and Housing** (ELD3900)
___ **Special Ed** (ELD8000)
___ **Special Needs Planning** (ELD3800)
___ **Sponsorship** (ELD6500)
___ **Technology** (ELD7800)
___ **Veteran's Benefits** (ELD6700)

NYSBA

The Latino Elderly in New York, an Introduction for Elder Law Attorneys: What You Should Know About the Fastest Growing Group in the United States

By Veronica Escobar

Editors' note: This submission, written by a first-generation American Latina attorney, gives the reader insight into the Latino community, and the specific challenges it faces, which affects the delivery of services by elder law attorneys.

Latino Demographics

What is a Latino? The term "Latino" refers to a person who was either born in or can claim descendance from Latin America: it is defined by geography. A Latino can be of any race, ancestry, ethnicity or religion, and can also speak a language other than Spanish (i.e., Brazilians speak Portuguese and Haitians speak Creole). The term "Hispanic" refers to a person who was either born in or can claim descendance from a Spanish-speaking country: it is defined by language.

For the purposes of this article we will use the term "Latino" to refer to a Spanish-speaking person of Latin American descent.

Latinos, including the aging, are a growing population in the United States. According to the most recently available statistics released in 2014 by the Administration on Aging (an agency within the U.S. Department of Health and Human Services), the over the age of 65 Hispanic/Latino population numbered approximately 3.6 million in 2014[1] and is projected to grow to approximately 21.5 million (to 22 percent) by 2060.[2]

Latinos comprised approximately 8 percent of the older population in the country in 2014.[3] In 2013, approximately 70 percent of the nation's older Latino population lived in four states; New York ranked fourth with 290,030 residents.[4]

This same year, 2013, approximately 66.4 percent of the total *general* New York Latino population resided in the five boroughs of New York City[5] while 13.1 percent resided on Long Island (Nassau and Suffolk Counties).[6] Close to 81 percent, or 2,830,813 of the Latino population of the state resided in the five boroughs and Long Island. The remaining 19 percent of the Latino population resided in the upstate counties. [7]

Unfortunately, there are no available statistics offering further details about the numbers of Latino elderly living in the boroughs of New York City. But information released in New York City's 2010 census revealed that approximately 38.2 percent of New York State's *general* 60-and-over population resided in New York City[8] and represented 17.2 percent of the city's population.[9]

Veronica Escobar

In 2014 statistics, 21 percent of New York State's Latino population spoke only English at home;[10] while 79 percent spoke a language other than English.[11] Thirty-nine percent of the New York Latino population was foreign born and their median age 42,[12] compared to the 61 percent U.S.-born with a median age of 22.[13]

Seventy four percent, the majority of Latinos in the United States, are citizens.[14] The New York statistics closely mirror those seen nationally as to citizenship.[15]

In terms of the undocumented population, although precise numbers can't be calculated, March 2010 statistics place that number at approximately 3.7 percent of the total Latino *and* Non-Latino United States population and 28 percent of the total foreign-born population.[16] In the year 2012, of the top 15 states with the largest undocumented population, New York State ranked fourth.[17] New York's share of the undocumented population in 2012 was approximately 750,000 (or 8.2 percent of the total in those top fifteen states).[18] In 2012, approximately 79 percent of the national unauthorized immigrant population was Latino.[19]

Latino Attorney Demographics

When looking inward at our profession, statistics reflect that it is not racially or ethnically diverse. In fact, it is the least diverse profession in the United States.[20]

Approximately 85 percent of the legal profession is white non-Latino.[21] Latinos comprise five percent of the legal profession nationwide.[22] In 2017, the total lawyer population in New York was 177,035.[23] For comparison, the 2016 figure was 175,195.[24] The last publicly available statistic, from the year 2000, put the number of Latino attorneys in New York State at 3,100; of that 2,378 were located in New York City.[25] In a more recent NALP survey of New York City-based law firms, approximately 5.14 percent or 626 Latinos (both male and female), were associates (out of a total associate pool of 12,172).[26] Latinas comprised approximately a little under half of that 5.14 percent (2.46 percent) of New York City-based associ-

ates.[27] In that same year there were only 162 (2.48 percent) Latino partners (0.67 percent of that 2.48 percent were Latinas), out of a total of 586 (8.97 percent) minority partners, which was out of a total of 6,534 partners city wide.[28] New York City Law firm attorneys amounted to approximately 12. 27 percent of attorneys statewide in 2017.[29]

This is the backdrop for the provision of legal services to a predominantly Spanish-speaking Latino population in New York.

Best Practice Studies

Studies in related professions can offer us insight into best practices. A 2014 financial study entitled "The Hispanic American Experience" offers valuable feedback about the Latino community and their interaction with service providers who, like us, work on sensitive issues.[30] There were 1,023 households participating,[31] and it reported on the financial planning and readiness of Latinos.

Participants indicated that the primary barriers to accessing services were lack of trust of service providers and lack of understanding of the financial products and services.[32] Based on this study, Latinos are half as likely than the general population to have a financial advisor and are "significantly" less likely to have been contacted by a financial advisor regardless of their income level.[33]

In the author's opinion the failure to be contacted is significant. Even more telling was that these same respondents stated they were likely to work with an advisor—if *contacted* (emphasis added).[34] The study also showed that the Latinos surveyed largely receive information or advice about finances from informal networks like family, friends, their local bank and the media (television, radio and social media).[35]

This same study found that the language spoken at home strongly influenced preferred professional providers.[36] Among those who spoke Spanish only or predominantly at home, half preferred a bilingual financial advisor[37] and 49 percent percent also indicated that having information written materials in their native language was important.[38] The latter is indicative of the need for more multilingual professionals and for accessible information in the areas of law as well.

Effects of Demographics on Quality of Long-Term Care

There are other studies specifically focusing on issues of aging, Latino elderly, and their long-term care. These reflect similar results as the financial study—with language, cultural competency as well as access to resources as the most important factors.

How many Latinos live in nursing homes in New York State? According to statistics from the Kaiser Family Foundation for 2014 (the latest year available), Latinos comprised 8.6 percent, or approximately 9,313, of nursing home residents in the state.[39] The total number of nursing residents in the state at the time was approximately 108, 291.[40]

According to a Centers for Disease Control Study on long-term care released in 2016 and looking at the years 2013-2014, it found Latinos were represented in adult day care programs at 20.3 percent nationally, while they only accounted for 7.7 percent, 5 percent and 5.5 percent of home health agency clients, nursing home and hospice residents, respectively.[41] They accounted for a mere 2.2 percent of assisted living residents.[42] Why is this important? There is existing literature that discusses the lesser quality of care Latinos receive in nursing homes.

A 2010 study, which looked at the years 2000 to 2005, found that while Latinos use long-term care services less frequently, they have a greater rate of disability than non-Latinos.[43] It also correctly stated that differences exist among the different Latino groups with regard to immigration patterns, education and income levels and these could account for disparities in long term care usage.[44] The results painted a picture of a group that is not homogeneous, but overall is receiving lower quality care in nursing homes compared to those where the majority of residents are white non-Latino. The study looked at disparities in nursing home performance by assessing nursing home deficiencies, staffing levels, and financial viability.[45] There were three nursing home categories: 1) those with no Latino residents, 2) those with a maximum of 15 percent Latino residents; and 3) those with 15 percent or more Latino residents.[46] The study found that the percentage of white non-Latino residents declined, while the percentage of Latinos increased, from 5 percent in 2000 to 6.4 percent in 2005.[47] The study found that the percentage of Medicaid supported residents in nursing homes with more than 15 percent Latino residents was 30 percent higher than in those with fewer Latinos and more than 60 percent higher in all white nursing homes.[48] Perhaps not coincidentally, elderly Latinos are more likely to reside in poor performing nursing homes than white non-Latino elderly.[49]

The authors of this study acknowledged that they could not account for differences in patterns among the different Latino groups.[50] There were also geographic differences, and this made it difficult to determine whether ethnicity or geography influenced the patterns.[51] Another factor is the varying migration patterns among the Latino groups; the time it occurred in history or their age at time of migration,[52] i.e., older Cuban Americans are more likely to be long-term U.S. residents compared to more recently arrived Mexican counterparts. This may be

advantageous to the former in accessing higher quality nursing homes.[53]

The authors further noted that they did not address the confounding variable of nursing home care quality with access to resources.[54] However, they did find that the more Medicaid dependent a nursing home is, the less likely it is to have access to resources to improve quality of care.[55] Under-resourced facilities care for a disproportionate number of patients both poor and from minority groups.[56]

A similar study, published a year later in 2011, found that changing demographics across the country appeared to drive the racial and ethnic makeup of nursing home residents.[57] It also remarked that changes in long-term care may also be responsible for the shifts and that as a result minority older people may face hurdles in accessing home and community-based care.[58] Hence the need for more legal services and providers in their dominant language, if that is Spanish, and in their geographic area.

In terms of the ethnic/racial minority elder nursing home population, the study found that between 1999 and 2008 it outpaced the same population as a whole in metropolitan areas with a high concentration of these populations.[59] Ultimately, the nursing home population should mirror the country's elder population.[60] Will nursing homes be able to provide culturally competent and sensitive care?[61] A closer analysis showed that the percentage of racial/ethnic minorities in nursing homes correlated to the overall percentage of elderly in the same minority group but that no such correlation existed for white non-Latinos.[62] The authors suggested that this meant the white non-Latino elderly had more options and more of an ability to pay for assisted living facilities.[63] In contrast, minority elders were more likely to have limited alternatives to nursing homes.[64] When they reside in nursing homes, the homes are usually of lower quality, with fewer resources, more reliance on Medicaid and less care than those in affluent communities.[65]

According to the National Hospice and Palliative Care Organization (NHPCO), less than 10 percent of eligible Latinos use hospice care nationally.[66] Some of the reasons for this are lack of knowledge and religious or spiritual beliefs.[67] It was also found that Latinos are less likely to complete advance directives and some of the factors are poor communication with their physicians, religious or spiritual beliefs and language barriers.[68]

The study highlighted that each ethnic group within the Latino ethnicity is different, and even more differences exist in each subculture within that group.[69] Families also have their own cultures.[70] Therefore, the authors recommended that properly trained bilingual staff is essential in order to make the information available and understood and[71] that workshops, seminars and courses should be provided to educate the community about the available options.[72]

In our profession, a good first step would be to have fully bilingual support staff. Proficiency in a language is insufficient, especially when it comes to important decision making. A further step would be to have this staff attend legal trainings to gain a better understanding of the law, the work you do and the clientele you serve. They should attend CLEs, not every single one that you do, but those that will serve to enhance their work and your practice. An even better step is to go out into the community and educate the public.

Not surprisingly, the authors found that more assimilated and higher socioeconomic status Latinos were more likely to use hospice.[73]

As attorneys, we can take away a few lessons from this. You must meet the client where they are and ensure that you have people working with you who are sensitive to and knowledgeable about the communities they intend to serve. I am fully bilingual; however, when I assist clients *who are Spanish-speaking only* in executing their advance directives, wills or other documents I make sure there is an official interpreter in the room.

While I read the English version of the document, the interpreter translates my words into Spanish. Even though I could easily read the document to them in Spanish, I personally feel I am better able to focus on my role as attorney by doing this. Obviously, if they have a question I counsel them in Spanish as I am an attorney and *counselor* at law. These are the roles I am best suited for.

Another study examined older Latinos' attitudes toward end-of-life planning,[74] and although the sampling was small,[75] the methodology used to assess the best way to provide guidance was insightful—and unsurprising. The subjects were divided among three groups: The "control group" received standard information; i.e., the New York State Health Proxy Form and instructional booklet in English and Spanish. The second group—"Conversación A" (Conversation A)—received a one-hour protocol in their homes, and there was a dialogue in Spanish that addressed Advance Directives, role of the agent, the importance of advance planning; medical, legal and value issues; and how to begin a conversation with loved ones and the standard information in the control group. The third group—"Conversación B" (Conversation B)—was the "intensive" in that, in addition to being conducted in Spanish and offering the same dialogue as in Conversation A, it also covered other themes developed in a focus group: burden of decision making, control (for decision making), communication, family relationships, religion and spirituality.[76] Of note is that the authors chose to work with majority Spanish-speaking individuals who, on average, had only completed up to a sixth-grade

education.[77] The authors admitted that findings could be different among Latinos with more education.[78]

Their study concluded that Conversation A made a significant difference in both attitudes toward and comfort with end-of-life planning, while Conversation B only made a significant difference in attitude.[79] The authors surmised that Conversation B was too much for a person to think about in one session; considering end-of-life is a difficult subject, and the authors felt the topic was a powerful one that deserved additional time—in a separate meeting.[80]

Additionally, the authors underscored the impact of a single session in the participants' native language as significant.[81] The study showed that, with respect to the control group, printed materials in Spanish were insufficient, especially if dealing with individuals with limited educations.[82]

From this author's experience working within the Latino community, it is often the adult children, sometimes U.S.-born, of Latino elderly clients who make the first contact with attorneys and other professionals. Typically, when I speak to the parent(s), they are often unprepared for aging and sometimes resistant to doing any kind of planning. This can be the result of factors such as lack of language sophistication, education, socioeconomic status, overall fear of the process and, sometimes, fear of family discord.

Many of the older Latinos who consult with me know what a Last Will and Testament ("a will") is; however, there are times when they have failed to know and/or recognize the value of advance directives. In other words, they are more familiar with the concept of death and the role a will plays upon death than they are with incapacity and why legal protection is necessary should they have a stroke, for example. Simply, they do not understand the breadth of the law available to protect them.

My experience has also shown me that Spanish-speaking clients whose adult children are more knowledgeable with respect to planning seem to be better prepared when they meet with me. The issues I mentioned are not foreign to elder law attorneys generally, but when language and culture are factors the attorney may not be equipped to address them.

Another interesting study was caregiving from the perspective of paid and family (unpaid) caregivers.[83] There were two essential criteria for the study: 1) that the caregiver identify as Latino/a, and 2) for the ill individual to have a terminal illness.[84] The sample was 20 caregivers and all were interviewed in their homes.[85] Half of them were caring for a person utilizing hospice services, while the other half was caring for a person not utilizing those services.[86] Thirteen caregivers were family and unpaid, while the remaining seven were paid caregivers.[87] Four of the unpaid family caregivers had no help; another four received help from other family members, while the remaining received help from a combination of family, friends and community.[88]

Twelve of the family caregivers preferred speaking Spanish.[89] The study related individual caregivers' stories in their own words and found that, in addition to the ill family member, many Latino caregivers have to deal with intergenerational issues, limited financial resources, and families fragmented due to geographic distance and immigration laws.[90] The authors stressed that the provision of respite and additional support for the caregiver are critical.[91]

Based on this author's own knowledge, the likely reason for caregiver respite is obvious: (1) when you are dealing with stressors, on top of caregiving for a loved one, there is not only strain on the caregiver and patient relationship, but negative impact on the caregiver. (2) Caregiver self-care is obligatory, irrespective of race or ethnicity. (3) In immigrant communities, with stressors that may not exist in longer established ones, self-care can be challenging or seemingly elusive to obtain, irrespective of race or ethnicity.

Lastly, but not less important, the study also emphasized how essential Spanish language written materials and bilingual medical and health and other professionals were, especially those trained to provide services understanding cultural idiosyncrasies.[92] The statistics and anecdotes underscore the importance of meaningful and personal outreach, education and cultural sensitivity, which may also include language competency and knowing that one size does not fit all—especially with such a heterogeneous group like Latinos. If these things were put into place, we would likely find a population more proactive in preparing for their old age and securing not only their financial futures but also that of their families. The public is there…you just need to know where and how to meet them.

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   Rockland County, *available at* http://www.pewhispanic.org/states/county/36087/; 50,686 or 16 percent of county population.

   Erie County, *available at* http://www.pewhispanic.org/states/county/36029/; 43,364 or 5 percent of county population.

   Dutchess County; *available at* http://www.pewhispanic.org/states/county/36027/; 32,136 or 11 percent of county population.

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15. American Bar Association, Commission on Hispanic Rights and Responsibilities: *Latinos in the United States Overcoming Legal Obstacles, Engaging in Civic Life* at 9 http://www.americanbar.org/content/dam/aba/images/commission_on_hispanic_legal_rights_responsibilities/hispanicreportnew.pdf 62.9 percent U.S. Born; 37.1 percent Foreign Born. Of the foreign born population, approximately 26.2 percent are non-citizens.

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Psychiatric Advance Directives: A New York Perspective

By Ronna Blau, Lisa Volpe, Christy Coe and Kathryn Strodel

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.[1]

I. INTRODUCTION

It is a firmly established principle in New York common law that every individual of adult years and sound mind has a right to determine what shall be done with his own body[2] and to control the course of his medical treatment.[3] Patient autonomy and self-determination are basic tenets of New York law that have been faithfully adhered to by courts[4] and codified in various statutes governing informed consent and health care decision making.[5] The priority of the patient's decision is a firmly ensconced principle in New York State law.[6]

As medical technology advanced it became clear, however, that there was a need for consistent decision making procedures for patients who lost decision making capacity. Beginning with California in 1976, all states enacted advance directive statutes of some sort, including either living wills (containing instructions about particular treatments and medical conditions) or durable powers of attorney (appointing a surrogate decision maker) or both.[7] In 1990, the federal Patient Self-Determination Act (PSDA) was enacted to promote the use of written advance directives.[8] Passage of the PSDA followed the United States Supreme Court June 25, 1990 decision in *Cruzan v. Director, Missouri Department of Health.*[9] Writing for a divided Court in a 5-4 opinion, Chief Justice Rehnquist determined, among other things, that the United States Constitution did not forbid Missouri from requiring that there be clear and convincing evidence of an incompetent patient's wishes relative to the withdrawal of life-sustaining treatment.[10]

The PSDA requires health care facilities receiving federal funds to inform patients of their rights under state law to prepare an advance directive, to inquire and document whether patients have executed a directive, to ensure compliance with state laws by respecting advance directives, and to educate health care providers regarding these legal instruments.[11] The same year the federal PSDA was enacted, New York amended its Public Health Law (PHL) to permit a patient with capacity to appoint a health care agent.[12] Codified at article 29-C of the PHL, the health care proxy statute was in derogation of the common law which, similar to the State of Missouri, did not permit a third person to make a decision to forgo life sustaining treatment on behalf of a patient lacking decision-making capacity in the absence of clear and convincing evidence of the patient's prior competent choice.[13] There is no legislation in New York expressly authorizing living wills, but they are recognized under the common law and health and mental health regulations[14] as evidence of the patient's intentions pertaining to the rendition or withholding of treatment. Moreover, New York's Family Health Care Decisions Act provides that there is no need to seek a surrogate decision about treatment, including life-sustaining treatment, if the patient already made the decision expressed in writing, which would include a living will.[15]

While legal scrutiny in New York has been afforded primarily to life sustaining treatment cases,[16] a legally authorized surrogate, such as a health care agent, is empowered to make any and all health care decisions on the principal's behalf that the principal could make.[17] This legal principle becomes particularly relevant when examining the use of psychiatric advance directives.[18] Courts have long recognized that all patients, including patients with severe mental illness, have the right to participate meaningfully in the course of their own treatment, to be free from unnecessary or unwanted medication, and to have their rights of personal autonomy and bodily integrity respected by agents of the state.[19]

A person is not deemed incapable of making medical decisions by simply virtue of a psychiatric diagnosis. Nonetheless, a mental illness may render a person temporarily unable to make informed choices regarding his or her care and treatment.[20] Psychiatric advance directives (PADs) were introduced as a means for people with psychiatric conditions to retain choice and control over their own mental health treatment during periods of decisional incapacity.[21] A PAD can be "instructive" enabling a person to specify treatment to be administered or refused when incapacitated, or take the form of a proxy directive permitting patients (principals) to appoint a representative to make health care decisions, or a combination of both.[22] Notably, the Center for Medicare and Medicaid Services (CMS) endorses the use of the PAD, recognizing that a PAD is akin to a traditional advance directive for health care. Further, CMS recommends that a PAD be accorded the same respect and consideration that a traditional advance directive for health care is given even where state law has not explicitly sanctioned their use.[23]

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II. A COMPARISON OF PAD STATUTES OF OTHER STATES AND THE NEW YORK HEALTH CARE PROXY LAW

Article 29-C of the Public Health Law makes no distinction between a health care agent's authority to make medical decisions and the authority to make mental health elections on behalf of a principal deemed to lack capacity. Health care for purposes of New York's statute is, in fact, defined as any treatment, service or procedure to diagnose or treat an individual's physical or mental condition.[24] In contrast, some states have specialized PAD statutes.[25] A PAD executed in another state or jurisdiction in compliance with the law of that state or jurisdiction shall be considered validly executed for purposes of New York law.[26] While New York is a general advance directive state, PAD forms are in use and available on line.[27] Research suggests that although 70% of patients with mental illness would want a PAD if offered assistance completing one, less than 10% have actually executed a PAD.[28] The literature is replete with analyses related both to the benefits and shortcomings of the PAD and confusion about the utility of PADs may be contributing to their underutilization in practice.[29]

Whether executed in an express PAD jurisdiction or in a general advance directive state such as New York, there are many benefits associated with PADs. These benefits include the potential to empower individuals with mental illness relative to their treatment choices, increase their satisfaction, motivation and treatment adherence, enhance continuity of care, promote early intervention and preventative care, encourage treatment collaboration and communication between the patient, family and clinical team, decrease reliance on coercive measures, assist in crisis de-escalation, and decrease hospitalization and the need for judicial intervention to compel treatment.[30]

Potential problems with PADs include insufficient education regarding the role of these instruments and the formalities associated with their execution as well as misunderstandings among clinical staff and providers regarding the utility of PADs. There are questions surrounding legality and liability, especially when a person elects to create a PAD to refuse treatment seen as critical in a crisis. There is also the potential for stigmatizing people with mental illness using distinct psychiatric advance directives (with their related rules and susceptibility to override by physicians) as somehow different from patients with cognitive impairments who complete general health care advance directives.[31] With respect to this latter pitfall, the potential for physician override of a PAD is perhaps the most controversial aspect of these advance planning tools.[32] In addition, there is little guidance on how laws governing mental health advance directives and civil commitment statutes are to be reconciled with one another.[33]

In states with PAD statutes, physician override of a PAD may be permitted under the following circumstances:

- where there is a court order finding incapacity;
- in case of emergency involving imminent threat of harm to the mental health service recipient or others; or where PAD instructions have not been effective in reducing the severity of the behavior causing the emergency; or, in an emergency where there is substantial risk of death or immediate and serious harm to the patient and within a reasonable degree of medical certainly the individual's health and safety would be affected adversely by delaying treatment;
- where there is a court order that contradicts the PAD instructions;
- where there is a court order authorizing involuntary commitment;
- where there is substantial evidence that failure to override would result in harm to the principal;
- if, in the opinion of the mental health professional, compliance with the PAD instructions is not consistent with generally accepted community standards of treatment, or the requested treatment is medically ineffective;
- if compliance is not consistent with court-ordered treatment.[34]

To date, the only reported decision interpreting a mental health advance directive statute in the commitment context is *Hargrave v. State of Vermont*.[35] In *Hargrave*, the Second Circuit Court of Appeals examined the validity of a Vermont statute that was alleged to violate the Americans with Disabilities Act (ADA). Pursuant to Vermont law, a civilly committed or imprisoned patient's previously executed durable power of attorney for psychiatric treatment preferences could be overridden through a petition by a health care professional to involuntarily medicate the patient. However, the procedure available to other incapacitated patients in Vermont allowed for a durable power of attorney for medical treatment preferences to be overridden in only two distinct circumstances; i.e., by the patient's revocation of the power of attorney or by a third party's petition to suspend the power of attorney in conjunction with the appointment of a guardian for the individual. According to the challenged statute, the committed patient's previously executed durable power of attorney would be honored for 45 days, during which the facility would observe any improvement to the patient's condition in the absence of the rejected medication. If no improvement appeared, the court would determine whether to forcibly administer the medication pursuant to the health care professional's petition. Plaintiff argued that the more relaxed override provisions pertaining to individuals with mental illness who were otherwise qualified to execute durable powers of attorney was discriminatory and violated the ADA.

The state-defendants in *Hargrave* invited the appeals court to hold that the initial judicial determination of dangerousness at the time of civil commitment was sufficient to exclude otherwise qualified mentally ill people from the protections of the ADA permitting the durable powers of attorney to be overridden. Specifically, the defendants maintained that the "direct threat" exception[36] of the ADA applied and that the exception continued for the entire length of the patient's commitment. The Second Circuit Court of Appeals ruled in favor of the plaintiff, however, concluding that the ADA's direct threat exclusion was inapplicable because Vermont failed to demonstrate that every civilly committed person subject to the statute's abrogation procedures posed a direct threat of harm to others sufficient to exclude her from the protections of the ADA.

The conclusion rested on two principles. First, the court observed that civil commitment in Vermont was based on a finding that the individual poses a danger to self or others, whereas the direct threat defense under the ADA requires the person to pose a risk of harm to *others*. Second, the court emphasized the significant delay in time between the initial civil commitment and abrogation of the durable power of attorney and the lack of an individualized hearing prior to the latter. By virtue of these findings, and others, the Second Circuit held that the Vermont statute impermissibly discriminated against qualified individuals who meet the essential eligibility requirements for maintaining durable power of attorneys and enjoined enforcement of the statute.

Given the decision in *Hargrave*, it appears that PAD-specific laws of other jurisdictions that permit a physician or court to override a person's prior capacitated choice are susceptible to challenge under the ADA. In contrast to Vermont, New York's health care proxy statute does not distinguish between medical and mental health treatment decisions and does not contain specific abrogation provisions. Absent conscience objections, a health care provider is obligated to comply with health care decisions made by an agent in good faith under a health care proxy to the same extent as if such decisions had been made by the principal.[37] Thus, the only limitations on the enforcement or revocation of advance mental health treatment directives in New York are potentially found in the state's civil commitment statutes,[38] under the common law[39] or under article 29-C itself which does not permit a health care proxy to be revoked by a principal determined by a court of law to be incompetent.[40] However, no reported decision in New York has squarely addressed these issues. The literature suggests that to survive scrutiny under the ADA, overriding PAD instructions can occur when the directive poses a direct threat to the health or safety of others or where there is a direct threat to the patient's life caused by a mental health emergency.[41] An individualized dangerousness assessment at the time of abrogation is also likely required to conform to the ADA.[42]

Also implicated in New York are statutory and regulatory strictures which must be satisfied before a health care proxy may be executed or revoked. In this regard, if a person executes a health care proxy while resident in a facility licensed or operated by the Office of Mental Health or the Office for People with Developmental Disabilities, witnesses to the proxy must have special clinical credentials.[43] The witnessing requirements are intended to ensure that the patient has capacity to execute the advance directive. Further, as provided for at section 2985 of the PHL, a competent adult may revoke a health care proxy by notifying the agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the proxy. For purposes of the statute, every adult shall be presumed competent unless determined otherwise pursuant to court order. Of course, in New York, only in rare instances do plenary adjudications of incompetence survive and thus, even a person with a legal guardian retains all powers and rights except those powers and rights which the guardian is granted[44] and thus, may be able to revoke a health care proxy or execute a new one.[45]

"Our state statute further provides certain safeguards to protect an individual's ability to challenge an unwanted health care decision even if she has been deemed incapacitated, thus, in effect, circumventing the inability to revoke."

Our state statute further provides certain safeguards to protect an individual's ability to challenge an unwanted health care decision even if she has been deemed incapacitated, thus, in effect, circumventing the inability to revoke. Section 2983 of the PHL provides, for instance, that notwithstanding a determination pursuant to this section that the principal lacks capacity to make health care decisions, where a principal does object to the determination of incapacity or to a health care decision made by an agent, the principal's objection or decision shall prevail unless the principal is determined by a court of competent jurisdiction to lack capacity to make health care decisions. Moreover, our state law permits the commencement of a special proceeding to resolve disputes arising under the law.[46] In the opinion of the authors, a principal's potential inability to revoke a health care proxy in the event of future incapacity should not dissuade the person from executing a PAD, nor outweigh the value of a PAD that expresses treatment wishes based upon past experiences and an understanding of treatment options. Furthermore, in a judicial proceeding, the treatment preferences articulated in a PAD would likely constitute clear and convincing

evidence of the individual's preferences and wishes, thus providing the court with a basis to determine whether a proposed treatment is appropriate for a person who has lost decisional capacity.

A concomitant issue is whether the mental health directives expressed in a PAD document could defeat a *Rivers* application commenced to override a patient's objection to the administration of psychiatric treatments.[47] It might be argued that if a *Rivers* application is commenced invoking the *paren patriae* powers of the state, a judicial override of PAD instructions can only occur upon an individualized finding of dangerousness to survive scrutiny under the ADA.[48] While a hospital cannot be prevented from commencing a *Rivers* proceeding, a PAD which contains articulated reasons for definitely expressed treatment preference may be instructive to fact finders. That is, the PAD may be used at both the administrative review preceding the *Rivers* application[49] and in court to aid the judge in narrowly tailoring any involuntary treatment order to give substantive effect to the patient's liberty interest.[50] At the very least, the PAD offers clear and convincing evidence of the patient's treatment preferences expressed at a time when the individual had the capacity to make treatment decisions that should be honored by the hospital and the court.

III. CONCLUSION

While New York does not have a specific mental health advance care directive statute, Article 29-C of the PHL provides for the appointment of a single health care agent empowered to make both medical and mental health care decisions. A principal is also permitted to include instructions regarding future care within her advance directive. Psychiatric advance directives are a valuable planning tool for people with mental illness. Their execution should be encouraged in order to afford individuals with mental disabilities the greatest autonomy possible in relation to their health care. There is uncertainty in the law as to whether and when a PAD may be overridden and the relationship between the PAD and civil commitment is ill-defined. Nonetheless, the potential for PADs to enhance the effectiveness of mental health treatment and avoid the need for involuntary care and treatment are laudable public health goals that should be pursued through education and outreach.

Endnotes

1. National Resource Center on Psychiatric Advance Directives: www.nrc-pad.org.
2. *Schloendorff v. Society of N.Y. Hosp*., 211 N.Y. 125, 129 (Cardozo, J.).
3. *In re Storar*, 52 N.Y.2d 363; *Schloendorff v. Society of N.Y. Hosp*., 211 N.Y. 125, *supra*).
4. *Rivers v Katz*, 67 N.Y. 2d 485, 492-493, *citing, Matter of Storar,* 52 N.Y. 2d 363, *supra, Matter of Harry M*., 96 A.D.2d 201.
5. PHL 2504, 2805-d.
6. PHL 2983(5), 2994-c (6).
7. Jeffery W. Swanson, PhD, S. Van McCrary, PhD., Marvin S. Swartz, MD., Eric B. Elbogen, PhD., and Richard A. Van Dorn, PhD., *Superseding Psychiatric Advance Directives: Ethical and Legal Considerations,* 34 J. Am. Acad. Psychiatry Law 385, 386 (2006).
8. Codified at 42 U.S.C.A. 1395cc (f).
9. 497 U.S. 269. The only other state with such a stringent rule was New York. *See Matter of Westchester County Med. Ctr. (O'Connor)*, 72 N.Y.2d 517.
10. The *Cruzan* majority also determined that state courts did not commit constitutional error in concluding that evidence adduced at trial did not amount to clear and convincing evidence of the patient's desire to cease hydration and nutrition; and finally, that due process did not require state to accept substituted judgment of close family members absent substantial proof that their views reflected those of patient. *See* 497 U.S. at 282-287.
11. 42 U.S.C.A. 1395cc (f). Despite the enactment of the PSDA, research suggests that the prevalence of written medical advance directives in the general public remains no higher than 25 percent and did not substantially increase after passage of the federal law. *See* Swanson, *supra* note 7, p 387 and authorities cited therein.
12. L. 1990, c. 752. The legislation was based upon the consensus recommendations of the Task Force on Life and the Law convened by Governor Mario Cuomo in March 1985.
13. *In re Westchester County Med. Ctr. (O'Connor)*, 72 N.Y.2d 517, 530-531 *supra.* In *O'Connor*, the Court of Appeals stated: Every person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment under some particular circumstances.
14. As stated in *O'Connor*, the ideal situation for evidence of a prior competent choice by a patient who now lacks decision making capacity is through a living will (72 N.Y.2d at 532). The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks. Further, a person who has troubled to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends. In contrast, a person whose expressions of intention were limited to oral statements may not as fully appreciate the need to rescind those statements after a change of heart (*id*.).
15. PHL § 2994-d.3(a)(ii).
16. *In re Storar*, 52 N.Y.2d 363, *supra; In re O'Connor,* 72 N.Y.2d 517 *supra.*
17. PHL 2982 (1).
18. *See* Judy Ann Clausen, *An Americans with Disabilities Act Critique of Advance Directive Override Provisions,* 71 N.Y.U. Ann. Surv. Am. L. 25, 26 (2015). General advance directives (generic directives) typically address end-of-life care, but mental health advance directives (mental health directives) govern treatment administered during periods of incapacity caused by acute mental illness episodes.
19. *See, e.g. Disability Rights New Jersey, Inc. v. Velez,* 974 F. Supp. 2d 705,709 (2013), *aff'd*, 796 F.3d 293 (3d Cir. 2015).
20. *Rivers v. Katz,* 67 N.Y.2d 485, *supra* note 4.
21. Swanson *et al*., *supra* note 7.
22. *See* Patricia Backlar, *Anticipatory Planning for Psychiatric Treatment Is Not Quite the Same as Planning for End-of-Life Care*, 33 Community Mental Health J. 261 (1997): *see also,* Clausen, *supra* note 17 at 33-34.
23. CMS State Operations Manual, Appendix A—Survey Protocol, Regulations and Interpretative Guidelines for Hospitals, Interpretive Guideline A -0132 p. 94-95.
24. PHL 2980(4). State law further provides that mental hygiene facilities (and residential heath care facilities) shall establish procedures: (a) to provide information to adult residents about their right to create a health care proxy; (b) to educate adult residents about the authority delegated under a health care proxy, what a proxy may include or omit, and how a proxy is created and revoked; (c) to help ensure that each resident who creates a proxy while residing at the facility does so voluntarily. *See* PHL 2991 (1).

25. National Resource Center on Psychiatric Advance Directives: www.nrc-pad.org; Clausen, *supra* note 17. The states with specialized PAD statutes are Arizona, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Montana, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Washington and Wyoming.
26. PHL 2990.
27. See, The Advance Directive Provider Training Project, New York Association of Psychiatric Rehabilitation Services, Planning for Your Mental and Physical Health Care and Treatment, http://www.nrc-pad.org - last visited March 19, 2017.
28. Eric Elbogen, Jeffrey Swanson, Paul Appelbaum, Marvin Swartz, Joelle Ferron, Richard Van Dorn, H. Ryan Wagnor, *Competence to Complete Psychiatric Advance Directives: Effects of Facilitated Decision Making*, 31(3) Law Hm. Bav. 275-289 (2007).
29. *See*, *e.g.*, Clausen, *supra,* note 17; Nat'l Ethics Comm. Veteran's Health Administration, *Advance Directives for Mental Health: An Ethical Analysis of State Laws & Implications for VHA Policy* (Feb. 2008), available on line at www.ethics.va.gov/docs/necrpts/NEC_Report_20080220_Adv_Directives_MH-Analysis of_State_Laws-Implications_for_VHA_Policy.pdf - last visited March 17, 2017.
30. Elbogen et al., *supra* note 27; *see also* U. Penn Collaborative on Community Integration, Psychiatric Advance Directives: Pros, Cons, and Next Steps. tucollaborative.org/pdfs/Toolkits_Monographs_Guidebooks/self_determination_psychiatric_advanced_directives_self_directed_care/Psychiatric_Advance_Directives.pdf, last visited March 17, 2017.
31. *Id.*
32. Swanson et al., *supra* note 7; Paul Appelbaum, *Commentary: Psychiatric Advance Directives at a Crossroads-When Can PADs Be Overridden*, 34 J. Am. Acad. Psychiatry Law 395 (2006).
33. Clausen, *supra* note 17, p. 35. There is no national consensus concerning the interaction of commitment statutes and mental health directives which is one reason why the Uniform Law Commission refrained from enacting a model mental health directive statute. *Id.* at p.37.
34. Clausen, *supra* note 17, p 50-61. In contrast, across jurisdictions, overriding a generic advance directive may occur when the patient's treatment preferences are (1) outside the standard of care; (2) unavailable; (3) medically ineffective; or illegal. *Id* at 49. *See* Uniform Health Care Decisions Act 7(e). 9 U.L.A. 27-28 (2010).
35. 340 F.3d 27 (2d Cir. 2003).
36. The ADA does not require an entity to permit an individual to participate in or benefit from the goods, services, facilities, privileges, advantages and accommodations of such entity where such individual poses a direct threat to the health or safety of others. The term "direct threat" means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services. 42 U.S.C. 12182(b)(3).
37. PHL 2984 (2-4).
38. *See* MHL 9.27, 9.33, 9.37, 9.39.
39. *Rivers v. Katz*, *supra* note 4, 67 N.Y. 2d 485.
40. PHL 2985 (1)(b).
41. Clausen, *supra* note 17, p 75-78.
42. Clausen, *supra* note 17, p 77.
43. PHL 2981 (1)(b)(c): *see also*, 22 NYCRR 22.3 - When a Patient May Sign Legal Instrument.
44. MHL 81.29 (a).
45. Robert Swidler, *Health Care Proxies—Ten Difficult Issues*, 88 N.Y.St. B.J. 28 (July/August 2016).
46. PHL 2992.
47. *Rivers v. Katz*, *supra* note 4, 67 N.Y. 2d 485.
48. Clausen, *supra* note 17, p 77.
49. *See* 14 N.Y.C.R.R. part 527.
50. *Rivers v. Katz*, *supra* note 4, 67 N.Y. 2d at 497–98.

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Fifth Annual *Elder and Special Needs Law Journal* Writing Competition

The Elder Law and Special Needs Section of the New York State Bar Association continues to strive to achieve a diverse membership body, in hopes of fostering a rich environment within which ideas are cultivated.

We are pleased to announce, the "Fifth Annual *Elder and Special Needs Law Journal* Writing Competition."

Topic: Any law or legal issue affecting seniors and/or persons with disabilities, with a specific focus on historically underserved populations. Examples include, but are not limited to, access to education, health care and housing.

Eligibility: All students attending an accredited ABA law school within New York State and recent law graduates seeking employment.

Awards: The winners of the "Fifth Annual *Elder and Special Needs Law Journal* Writing Competition" will be guaranteed publication within the New York State Bar Association's *Elder and Special Needs Law Journal* (ESNLJ). In addition, there will be two $1,000 prizes and a complimentary one-year membership in the New York State Elder Law and Special Needs Section for the winners.

Format: Submit the article in the form of a Word document. Please do not use Word Perfect or .docx. The article should contain endnotes in Arabic numerals, and all sources should be attributed in *Bluebook* format. Contact the Co-Production Editor for further details or your Office of Student Life or its equivalent.

Judging: The articles will be judged by the *ESNLJ* Editorial Board. Even if one of your students' articles is not chosen as a winner, we may choose to publish it in the *ESNLJ*.

To Enter: Please send all submissions to the following email addresses:

kimtrigoboff@gmail.com &
jseminara@gylawny.com

Deadline: March 15, 2019 and no extensions will be granted.

New York Article 9 Proceedings: Hospitalization of the Mentally Ill

Jamie A. Rosen

The principal statute governing the treatment of mentally ill patients in New York State is Mental Hygiene Law, Article 9. Psychiatrists, social workers, other hospital staff and administration who are involved in the treatment of psychiatric patients, as well as legal counsel for the hospital, must be familiar with the Mental Hygiene Law and related statutes, regulations and requirements imposed by the leading court cases. Privately retained attorneys for individuals and families in the community, as well as attorneys for skilled nursing facilities or assisted living facilities, should also be familiar. Education in this area of law, which very often overlaps with elder law, and knowledge of the treatment options for potential clients and their loved ones, is essential to an attorney's ability to then advise the client and implement a strategy to achieve the client's goal. This article provides an overview of Mental Hygiene Law Article 9, including hospital admission and retention, treatment over the patient's objection, assisted outpatient treatment, and mental hygiene warrants, as well as a brief discussion of the individuals involved in these proceedings, patients' rights and the role of family members.

Jamie A. Rosen

Admission and Retention

Psychiatric hospitals offer a safe setting for mental health treatment, including observation, diagnosis, therapy and medication management.[1] Article 9 sets forth the legal requirements for voluntary, involuntary and emergency admission to a hospital, as well as retention of patients pursuant to a court order.[2]

An individual may be admitted for psychiatric treatment as a voluntary patient, meaning that he or she has willingly made a written application for admission and is in need of care and treatment.[3] "In need of care and treatment" means "that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate."[4] The phrase "voluntary," however, can be misleading. If a voluntary patient wishes to leave the hospital, he or she must give written notice and cannot simply check him or herself out of the hospital against medical advice. The patient must be released unless the director believes that the patient requires involuntary care and treatment.[5] If such a determination is made, the patient may be retained for no longer than 72 hours from the time of the patient's written notice.[6] Before the expiration of the 72-hour period, the director must release the patient or apply to the Supreme Court in the county where the hospital is located for an order authorizing the involuntary retention of the patient.[7] If the court makes the determination that the patient requires involuntary care and treatment, the court will issue an Order authorizing the patient's involuntary retention for a period of up to 60 days.[8]

New York has civil commitment laws for situations where treatment is appropriate for individuals suffering from a mental illness who refuse to seek treatment voluntarily. Involuntary admission for treatment is a more restrictive form of intervention and has been characterized as a "massive curtailment of liberty."[9] The hospital must demonstrate that the patient suffers from a mental illness "for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he [or she] is unable to understand the need for such care and treatment."[10] Constitutional due process requires that the continued commitment of a patient be based upon a finding that "the person to be committed poses a real and present threat of substantial harm to himself or others."[11] This standard requires a showing that the patient has made threats of or attempts at suicide or serious bodily harm "or other conduct demonstrating that the person is dangerous to himself or herself" or homicidal or other violent behavior that places others in reasonable fear of serious physical harm.[12]

Involuntary admission by medical certification requires that two physicians certify that the individual is mentally ill and requires involuntary care and treatment in a hospital.[13] This type of admission, often referred to as a "2 *PC Admission*," requires that two physicians examine the patient within 10 days of admission to the hospital and each execute a separate certificate including the facts forming the basis of the physician's opinion that the person requires involuntary care and treatment.[14] These two certificates must be accompanied by an application for the admission of such person, whether by a family member, the director of the hospital, or the supervising or treating psychiatrist.[15] An involuntary admission by medical certification is valid for up to 60 days from the date of admission or conversion to involuntary status.[16]

For an emergency admission, the statute allows for a staff physician, not necessarily a psychiatrist, to perform the initial examination of the patient. The staff physician must determine that the patient allegedly suffers from "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate, and which is likely to result in serious harm to himself [or herself] or others."[17] The patient must then be examined within 48 hours by a staff psychiatrist and, if the individual meets the criteria, then he or she can then be retained in the hospital for a period of up to 15 days.[18] If the patient requires further

inpatient hospitalization beyond the 15-day admission, the patient must be converted to involuntary status by medical certification, as described above, to extend the retention to a period of up to 60 days from the date of admission.[19]

During the various retention periods, the patient, or someone on the patient's behalf, has the right to request release from the hospital, in writing.[20] The request for a court hearing must be immediately set for the next available court date. At the hearing, the hospital bears the burden of proof, by the "clear and convincing evidence" standard, that the patient meets the criteria for inpatient admission pursuant to the statute applicable to the patient's legal status. If it is determined that the patient requires involuntary care and treatment, the court shall deny the patient's request for release and the patient shall remain in the hospital for the remainder of the retention period.

If the hospital believes that a patient requires further inpatient hospitalization beyond the 60-day retention period, the hospital can apply to the court for an order authorizing continued retention for an initial period of time not to exceed six months from the date of the Order.[21] If the patient objects and requests a hearing, the procedure followed is essentially the same as when a patient requests a hearing pursuant to Mental Hygiene Law, Section 9.31.

Treatment Over Objection

When an individual is involuntarily committed for psychiatric treatment, that patient still retains the right to refuse treatment. The leading case in New York, *Rivers v. Katz*,[22] decided by the Court of Appeals, held that neither the fact that a patient is mentally ill nor that they have been involuntarily committed, without more, is sufficient to conclude that the individual lacks the capacity to understand the consequences of their decision of refuse treatment.[23] Therefore, when a patient refuses psychiatric medications or other treatment, "there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to the proposed treatment" before the treatment may be administered.[24] Before applying for a court order authorizing treatment over the patient's objection, first the hospital must follow strict administrative procedures.[25] At a *Rivers* hearing, the hospital bears the burden of proof, by clear and convincing evidence, that the patient lacks the capacity to make a reasoned decision about the treatment and that the proposed treatment is in the patient's best interests and narrowly tailored, taking into consideration the benefits, adverse side effects and any less intrusive alternative treatments.[26] This hearing is similar to the retention hearings described above, including testimony by the treating psychiatrist and the opportunity for the patient to testify as well.

Assisted Outpatient Treatment

When a patient is discharged from inpatient treatment in a hospital, non-compliance with outpatient treatment is often a recurring issue. The patient may fail to fill their prescriptions and take recommended psychiatric medication and/or may refuse to attend outpatient appointments with a psychiatrist or other mental health professional. In this case, the person's condition may deteriorate, he or she will likely require hospitalization again, and the whole admission process starts over. In New York, and many states across the country, legislators have made considerable efforts to prevent this hospital recidivism by allowing a court to authorize mandatory outpatient treatment and funding services to monitor compliance with that treatment.

The applicable statute in New York for Assisted Outpatient Treatment (AOT) is often referred to as "Kendra's Law."[27] In 1999, Kendra Webdale was pushed into the path of an oncoming subway train in Manhattan by a man who had a long history of mental illness and prior psychiatric hospitalizations.[28] AOT is meant to provide a less restrictive alternative to involuntary hospitalization. The goal of court-ordered outpatient treatment is to treat the person's mental illness, assist the person in living and functioning in the community, and/or to attempt to prevent a "relapse or deterioration" in the person's condition.[29] In order to achieve this goal, the outpatient treatment plan, to be approved by the court, can include, but is not limited to, case management services or assertive community treatment (ACT) team services, medication, periodic blood tests or urinalysis to determine compliance with prescribed medications and/or to detect the presence of alcohol or illegal drugs, individual and/or group therapy, partial hospital programming, alcohol or substance abuse treatment, and/or supervision of living arrangements.[30]

AOT can either be used as a discharge planning tool for hospitalized patients or as a community resource to support and supervise mental health treatment outside of a hospital setting. As part of a hospital discharge plan, AOT can help provide a smoother transition from the highly controlled environment of an inpatient psychiatric unit to an unstructured, unsupervised life in the community. In this case, the application for AOT is filed by the patient's treating psychiatrist before the patient is discharged. For those individuals already living in the community, the application can be filed by a family member, friend, mental health professional or other concerned individual in the county where the individual resides.

In order to qualify for AOT, the individual must meet certain criteria. The court must find that the person (1) is 18 years of age or older; (2) suffers from a mental illness; (3) is unlikely to survive safely in the community without supervision; (4) has a history of lack of compliance with treatment for mental illness that has:

> (i) prior to the filing of the petition, at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other

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The Elder Law and Special Needs Section's Young Lawyer Event at the Metropolitan Museum of Art

By Katy Carpenter

Young Lawyers Corner
For the Newly Admitted Attorney

The Elder Law and Special Needs Section's Young Lawyer Committee held its first event on Sunday, May 6th. Seventeen recently admitted attorneys scavenged their way through the Metropolitan Museum of Art in New York City as part of a Murder Mystery hunt, followed by cocktails and networking at the Met's rooftop bar. This event is part of an ongoing outreach to build a stronger foundation for the younger and newer members of the Section by offering opportunities to meet each other, network and build working relationships. The group also offers assistance for young lawyers who are interested with finding a mentor within the Section or committee placements.

For any questions, contact Lauren Sharkey (LSharkey@cswlawfirm.com) or Katy Carpenter (kcarpenter@wplawny.com), Young Lawyer liaisons—a subcommittee of the Elder Law and Special Needs Section's Membership Committee.

NEW YORK STATE BAR ASSOCIATION

Elder Law and Special Needs Section

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A unique event that features small breakouts designed to encourage open and free-flowing discussions on any subject affecting you and your practice. Topics are selected by the attendees and discussions are facilitated to permit the free sharing of ideas.

NYSBA

The Elder Law and Special Needs Section at the 2018 *UN*Program

The 2018 **Unprogram** took place at the Desmond in Albany this past April 19th and 20th. Shari Hubner and Antony Eminowicz once again organized a wonderful meeting with multiple facilitated breakout sessions. The **Unprogram**, which is held by our Section every other year in the Spring, provides a wonderful opportunity for members of the Section to discuss topics and issues of import to them in a welcoming informal environment that fosters in depth discussion and camaraderie.

Section Members Cheer the Unprogram!

"Joining the Elder Law Section of NYSBA has made a great deal of difference in my practice. I am very impressed with the caliber of the members of the Committee and the publications. I attended the **Unprogram** in Albany this Spring and met many people who were most helpful with the "nuances" and substance of Elder Law. They have become valued resources for me and I look forward to being at the Summer meeting in July."

- Kathleen C. Peer, Hudson, New York

"The **Unprogram** is hands down my favorite program that the Elder Law and Special Needs Section organizes. As a young attorney, the small group sessions allow me the opportunity to comfortably pose questions to more experienced attorneys without fear of judgment. After attending this year's **Unprogram**, I walked away with a genuine feeling of camaraderie and support from my colleagues and a true reminder of why I love this area of practice."

-Jessica R. Coombs, Glens Falls, New York

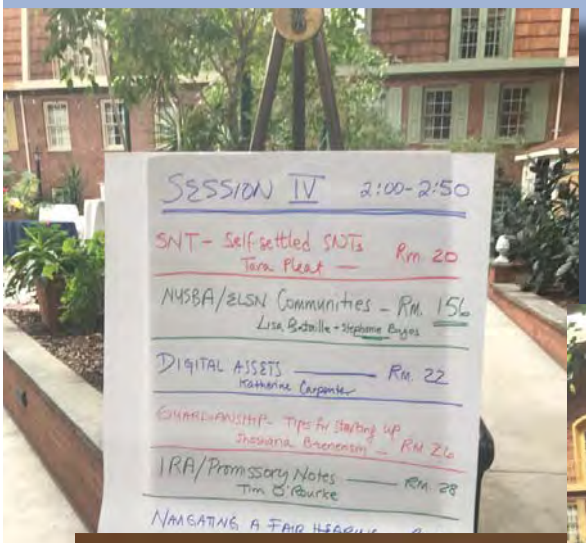
"The **Unprogram** was an amazing and enriching experience. Not only was it very informative but it was a great opportunity to interact and engage with seasoned attorneys in the profession."

Johanna David-Young, New York City

"The **Unprogram** was by far the best program I have attended. As a solo-practitioner, I appreciated the opportunity to ask questions, share ideas, and create new connections with colleagues. Thank you to the organizers and participants!"

Megan Harris-Pero, Esq, Saratoga Springs, New York

Please save the date for our next Section Unprogram, which will be April 30th-May 1st, 2020, at the Desmond in Albany!



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> mental health unit of a correctional facility or a local correctional facility, not including any current period, or period ending within the last six months, during which the person was or is hospitalized or incarcerated; or
>
> (ii) prior to the filing of the petition, resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any current period, or period ending within the last six months, in which the person was or is hospitalized or incarcerated;

(5) is unlikely to voluntarily participate in the recommended treatment; (6) needs AOT in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others"; and (7) is likely to benefit from AOT.[31] If the court finds by clear and convincing evidence that the individual meets the criteria, the court can issue an Order directing the individual to comply with the mandatory outpatient treatment services provided in the treatment plan for an initial period not to exceed one year.[32]

If the individual is non-compliant with a court order authorizing AOT, there is "no punitive remedy."[33] The individual can be transported to a hospital for a psychiatric evaluation and potential admission to the hospital for inpatient treatment.[34] For example, law enforcement officials, an ambulance service, or members of a mobile crisis outreach team can take the individual into custody and transport him or her to a hospital.[35] Then, the process of potential admission, retention, and treatment, as described above, starts over.

Mental Hygiene Warrants

Family members and caregivers, however, should not have to wait until their loved one hurts himself, herself or another person before he or she can be evaluated and treated in a hospital. In New York, family and other concerned individuals can make an application to the court for a "Mental Hygiene Warrant," an order for immediate evaluation in an emergency room not to exceed 72 hours.[36]A Mental Hygiene Warrant proceeding is a civil proceeding that involves petitioning the court, in the county where the individual resides, to issue a warrant to bring an allegedly mentally ill individual to court for a hearing. The petition must contain sufficient information to demonstrate that the individual allegedly suffers from a mental illness and is "conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself."[37] The individual is appointed counsel through Mental Hygiene Legal Service, or can retain a private attorney. At the hearing, the petitioner must demonstrate that the individual has or may have a mental illness that is likely to result in serious harm to himself or herself or others.[38] If the court determines that this burden has been satisfied, the court can order the removal of the individual to a hospital or comprehensive psychiatric emergency program for immediate evaluation not to exceed 72 hours.[39] At any time during the 72-hour period, the patient may, if appropriate, be admitted as a voluntary or involuntary patient. If it is determined that the patient does not meet criteria for admission, he or she must be released.

Who's Who in an Article 9 Mental Hygiene Court Proceeding

There are many individuals involved in Article 9 matters, both legal professionals and clinicians, beginning with the admission of the patient to the hospital and following that patient all the way through to the actual court hearing, if any.

Mental Hygiene Legal Service (MHLS) is a New York State agency that provides legal assistance to patients or residents of a facility, such as an inpatient psychiatric unit, and to persons alleged to be in need of care and treatment in such a facility.[40] When a patient is admitted to a hospital for psychiatric treatment, the hospital must inform the patient in writing of his or her legal status and rights under Article 9. Those rights include, but are not limited to, due process[41] and the availability of representation by MHLS.[42] MHLS is responsible for representing, advocating and litigating on behalf of these patients. MHLS is available for issues related to the admission and retention of patients in a mental hygiene facility as well as court-ordered assisted outpatient treatment, mental hygiene warrants, Article 81 Guardianship proceedings, and various other legal matters under the Mental Hygiene Law. The patient also has the right to retain private counsel.

A Supreme Court judge presides over a mental hygiene hearing in the State of New York.[43] The hearings often take place in the Supreme Court building of the county where the individual resides and/or is currently a patient. On other occasions, the hearings take place on site at a psychiatric facility.

In a mental hygiene hearing, whether for retention, treatment over objection or AOT, the court will first hear testimony from a representative of the hospital, usually the treating psychiatrist. The attorney for the hospital performs the direct examination of the psychiatrist. The psychiatrist is proffered as an expert in the field of psychiatry, by establishing his or her credentials such as attendance at medical school, completion of a residency program in psychiatry, licensure to practice medicine, board certification in psychiatry, and employment as a psychiatrist. The patient's medical record[44] at the facility where he or she is currently a patient will often be admitted into evidence as a business record.[45] Due to the potential inclusion of hearsay within the medical record, such as statements made by family members or outpatient treatment providers, the repetitive nature of a clinical record, and other common

evidentiary objections by the patient's attorney, some justices will deny a request to enter the entire medical record into evidence. Whether admitted into evidence or not, the psychiatrist will normally be permitted to review the medical record when testifying to refresh his or her recollection. The psychiatrist, as an expert, is permitted to give opinion testimony[46] as to the diagnosis of the patient, current symptoms, likelihood of posing a risk of harm to self or others, insight into the need for psychiatric treatment, capacity to make a reasoned decision about the proposed treatment plan, and several other areas that make up the elements of the hospital's case, depending on the type of hearing. The psychiatrist will testify based upon his or her own observations and examination of the patient as well as discussions with the patient's treatment team and a review of the patient's medical record.

On occasion, the court may hear testimony from a family member, friend, case manager, or other individual in the community who has direct knowledge of the individual's illness, treatment, behaviors, or symptoms that fall outside the knowledge of the treating psychiatrist and/or hospital staff. Information regarding the circumstances that led to the current hospitalization can help shed light on the patient's pattern of symptoms, noncompliance with treatment in the community, ability to care for self at home, and potential risk of harm to self or others in the community.

The patient has a right to be present and testify at these mental hygiene proceedings. Usually the patient's attorney will pose questions to the patient in the form of a direct examination and the patient is also afforded the opportunity to make a statement to the judge. The patient can then be cross examined by the hospital's attorney.

Conclusion

New York has established a comprehensive set of laws to promote the mental health of its citizens.[47] The various legal and clinical tools available through Article 9 help to ensure that individuals suffering from a mental illness have access to treatment in a hospital setting and appropriate services and supports to survive safely in the community.

Endnotes

1. *Psychiatric Hospitalization*, National Alliance on Mental Illness, available at http://www.nami.org/Template.cfm?Section=About_Treatments_and_Supports&Template=/ContentManagement/ContentDisplay.cfm&ContentID=150789.
2. Mental Hyg. L., Art. 9.
3. Mental Hyg. L. § 9.13(a).
4. Mental Hyg. L. § 9.01.
5. Mental Hyg. L. § 9.13(b).
6. *Id*.
7. *Id*.
8. *Id*.
9. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).
10. Mental Hyg. L. § 9.01.
11. *Scopes v. Shah*, 59 A.D.2d 203, 205, 398 N.Y.S.2d 911 (3d Dep't 1977); *see*, *e.g.*, *O'Connor v. Donaldson*, 422 U.S. 563 (1975).
12. Mental Hyg. L. § 9.01.
13. Mental Hyg. L. § 9.05(b), § 9.27(a).
14. Mental Hyg. L. § 9.05(b).
15. Mental Hyg. L. § 9.27(b).
16. Mental Hyg. L. § 9.13(b).
17. Mental Hyg. L. § 9.39(a).
18. *Id*.
19. Mental Hyg. L. § 9.39(b).
20. Mental Hyg. L. § 9.13; § 9.31(a), (b); § 9.39(a)(2).
21. Mental Hyg. L. 9.33(a), (b).
22. 67 N.Y.2d 485, 495 N.E.2d 337 (1986).
23. *Id*. at 495.
24. *Id*. at 497.
25. *Id*. at 486-87; *See* N.Y. Comp. Codes R. & Regs. tit. 14, § 527.8.
26. *Id*. at 486-87.
27. Mental Hyg. L. § 9.60.
28. *See* Patricia and Ralph Webdale, *Our Daughter Did Not Die In Vain*, Daily News, Jan. 3, 2013.
29. Mental Hyg. L. 9.60(a)(1).
30. *Id*.
31. *Id*.
32. Mental Hyg. L. 9.60(j).
33. *In re Urcuyo*, 185 Misc. 2d 836, 849, 714 N.Y.S.2d 862 (Sup. Ct. 2000).
34. Mental Hyg. L. 9.60(n).
35. *Id*.
36. Mental Hyg. L. § 9.43.
37. *Id.*
38. *Id*.
39. *Id.*
40. Mental Hyg. L., Art. 47.
41. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).
42. Mental Hyg. L. § 9.07(a).
43. For a similar overview of Mental Hygiene Hearings in New York from the perspective of an acting Supreme Court justice in New York County, *see* Mickey Keane, Hon. Gerald Lebovits, *Mental Hygiene Hearings in New York*, N.Y. St. B.J., June 2016.
44. Pursuant to Mental Hygiene Law Section 33.13(a), a facility licensed or operated by the New York State Office of Mental Health is required to maintain a clinical record for each patient.
45. N.Y. CPLR 4518.
46. N.Y. CPLR 4515.
47. New York State Office of Mental Health, Statewide Comprehensive Plan, 2016-2010, at 1, https://www.omh.ny.gov/omhweb/planning/docs/507-plan.pdf.

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Senior Member Spotlight: Anthony Enea

Q Where are you from?

A White Plains, New York in Westchester County. I was born and raised in White Plains and moved to Somers 25 years ago.

Q What do you like about the area and community in Westchester?

A Westchester County is beautiful; we have both the Hudson River Valley and Long Island Sound within minutes of each other. White Plains is also a very business-minded city and an excellent place to work. I am fortunate to be able to live and work near my family and where I grew up. My family has lived in White Plains since the early 1900s.

Q What is the most memorable and favorite place you have traveled to?

A Definitely, Italy. The history and culture are fascinating. I am a big fan of their diverse regional cuisines.

Q Tell me about your family/kids.

A have been married for 33 years to my wife, Joanne, a wonderful wife, mother and homemaker. We have two kids, Lauren and Michael. Lauren is an Associate in my office and Michael just finished his second year at St. John's Law School. I am very proud that Lauren graduated second in her class in law school and that Michael is a top ranked student in his class and a summer associate at Weil Gotshal in New York City.

Q What's your favorite part about your job?

A I have always had a great deal of respect for seniors and I enjoy helping them with their long-term care planning needs. I find it rewarding to be able to assist in preserving the life savings of our clients and helping them navigate the issues and complexities of aging. Being able to give back to our profession has been very rewarding.

Q Tell me about a project or accomplishment that you consider to be the most significant in your career.

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New Member Spotlight: Lauren Enea

Interviews by Katy Carpenter

Q Where are you from?

A I'm from Somers, New York, in Westchester County. Other than college, I have spent my whole life in Westchester.

Q What do you like about the area and community you serve?

A Westchester County is a very tight-knit community. I enjoy visiting the small towns and villages and frequenting the small businesses and local shops.

Q Where is your favorite place you've traveled to?

A I am not sure if I have a favorite! I travel to Florida and Cape Cod with my family every year. My dad and I are both "foodies" and we enjoy going to some of our favorite restaurants in both locations. My most interesting and rewarding travel experience is when I had the opportunity to travel to Italy and Spain in college.

Q Why did you choose to practice in the areas of Estate Planning and Elder Law?

A Originally, I wasn't sure I wanted to go to law school. I was a Business Management major in college but ended up enjoying my legal studies classes more than my business ones! I chose to practice in Estate Planning and Elder Law because I find working with the senior community very rewarding. As a child, I was exposed to this area of law and recall watching my father serve as guardian for an elderly disabled man. My father would also visit him regularly and around the holidays. I remember wrapping presents for him and buying cookies for him as a child. This experience in particular was one that made me want to practice elder law.

Q How is it working with your dad?

A We have a really great working relationship. I enjoy being able to assist him and the other partners and associates as we continue to grow and improve the firm together. I grew up at the firm and working at a place that means so much to me on both a professional and personal level is very rewarding.

Q What's your favorite part about your job?

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Anthony Enea, continued from page 29

A Being Chair of the Elder Law Section definitely comes to mind as well as being President of the Westchester County Bar Association and my current role as President of the Westchester County Bar Foundation.

Q Have you had any turning points in your life?

A Yes, when I traveled to Italy at 12 years old and saw the poverty and devastation caused by a massive earthquake. It was a wake-up call. It made me more aware of how fortunate I was to be living in the United States, and made me much more serious about my studies.

Q What led you to a career in law?

A I was always fascinated with the law. I grew up in the age of Perry Mason, a time where attorneys were respected and admired and considered an important part of society.

Q How is it working with your daughter?

A Fantastic! It's a real pleasure to work with Lauren; she is a great asset to the firm. In her first two years of practice she has made some significant improvements to our office management and technology.

Q Where do you see yourself in five years?

A Right behind my desk. They will have to take me out of my office feet first!

Q What did you want to be when you were younger?

A Always a lawyer.

Q Are there hobbies you look forward to on the weekends?

A I really don't have any "hobbies" per se, but I do enjoy playing golf and tennis. I spend most weekends writing articles and preparing for speeches and CLEs. Having dinner on the weekends with my family is the highlight of the week. I grew up having large family dinners and really enjoy family time spent around the table.

Q Is there anything else you want people to know about you?

A That I have spent over 30 years advocating for seniors and the disabled. I am a devoted elder law and special needs practitioner who truly cares about providing our clients with the best and most cost-efficient legal services possible.

Lauren Enea, continued from page 29

I love meeting with clients. I enjoy reviewing and explaining the documents and supervising will executions. I also like how most of our practice is about planning for the future. I feel that with many areas of law an attorney is not called until an issue in the client's life arises; I like to hope that our clients come to see us to help ensure that issues don't arise in their future.

Q Tell me about an accomplishment that you consider to be the most significant in your career thus far.

A I've been practicing for just over a year in New York and in that time I also studied for the Florida Bar and am admitted in Florida. I have also been very active in the Columbian Lawyers Association of Westchester County and have implemented a new software for office management that has changed how we handle matters within the office.

Q Where do you see yourself in five years?

A Continuing to practice and doing more seminars and presentations. I hope to be more involved in our local Bar associations and I would like to take advantage the leadership positions our Bar associations have to offer.

Q What did you want to be when you were 13?

A I was a dancer when I was 13 and I wanted nothing more than to be a Rockette at Radio City Music Hall. Unfortunately, that dream was quickly quashed when I learned I was too short!

Q Tell me a little about your family.

A I'm engaged to my fiancé, Brian, who is a police officer in Yonkers. We are college sweethearts and our wedding is planned for October. I have a great relationship with my parents and my younger brother, who just finished his second year at St. John's Law school.

Q Are there hobbies you look forward to on the weekends?

A I enjoy spending time with my family and cooking on the weekends. I love trying new recipes.

Q Have you ever been given memorable advice?

A My parents always told me to "just try your best." I have found that as long as I try my best, I have never let myself down.

Obviating the Need for Guardianship With Powers of Attorney: It's Not as Easy as You Think

By Daniel J. Reiter

I. Introduction

There is a widely held belief among practitioners that a valid power of attorney and health care proxy, in effect, will always obviate the need for guardianship. This is not the case. Despite the broad and expansive powers granted an agent in letter "O" of the N.Y. General Obligations Law § 5-1513 (GOL) statutory short form power of attorney, or the N.Y. Public Health Law § 2981 (PHL) form health care proxy, agents are, on occasion, unable to make certain decisions on behalf of their incapacitated principals, and guardianship may be necessary despite what appeared to be comprehensive planning prior to incapacity. This article discusses certain powers that (arguably) *can* be added to the statutory short form power of attorney to expand the agent's powers beyond the statutory limitations in order to avoid guardianship, certain powers that can *never* be exercised by an agent or a guardian, and a means to include these provisions in a power of attorney during the planning process.

II. An Instructive Example: Choosing the Place of Abode

In *In re Julia C.,* the son of the alleged incapacitated person, Julia C., petitioned for the appointment of a guardian for the person and property of Julia C. pursuant to N.Y. Mental Hygiene Law article 81 (MHL).[1] Julia C.'s daughter, the respondent, alleged that there were less restrictive alternatives, and available resources in place, to meet Julia C.'s needs, namely a power of attorney and health care proxy.[2]

With regard to the statutory short form power of attorney in place, respondent-daughter argued that the power of attorney executed by Julia C. gave Julia C.'s agents the power to choose her place of abode.[3] The court held otherwise.[4]

> Here, the power of attorney signed by Mrs. C. contains the standard powers designated under General Obligations Law 5-1501, together with additional powers such as access to medical records, establish and fund trusts and to do any act necessary to maintain the principal's standard of living. The Court finds no power for the attorney-in-fact to choose the place of abode. The Court will not read paragraph O[5] [all other matters] to give carte blanche authority to an attorney-in-fact to exercise powers clearly outside the contemplation of the power of attorney.[6]

Daniel J. Reiter

Pursuant to MHL article 81.22, a guardian may choose its ward's place of abode (with restrictions).[7] The court in *In re Julia C.* does not affirmatively decide whether the choice of abode is a power that a principal can include in the modifications section of the statutory short form power of attorney, but the decision is instructive.[8] One could argue that the court's analysis leads the practitioner to infer that such a power *can* be added to the modifications section (or could be included in a custom power of attorney) because the court's analysis does not turn on whether such a provision would have been valid, but whether such a provision was included in the power of attorney at issue.[9]

Yet, GOL § 5-1503, which governs the modifications section of the statutory short form power of attorney, states that a modification *is valid* if it meets one of the following three requirements: (1) the modification eliminates from the statutory short form power of attorney (or statutory gifts rider) one or more of the powers enumerated in the constructional sections of the statute, affirmatively chosen by the principal; or (2) supplements one or more of the aforesaid powers, affirmatively chosen by the principal, by specifically listing additional powers of the agent; or (3) **makes some additional provision which is not inconsistent with the other provisions of the statutory short form power of attorney or of the statutory gifts rider.[10]** This last point, (3), on its face arguably enables the principal to give an agent broad authority, which may not even relate to property management, so long as the addition in the modifications section is not inconsistent with any other provision in the statutory short form power of attorney.[11] Furthermore, GOL § 5-1502G(10) grants an

agent the power "to do any other act or acts, which the principal can do through an agent."[12]

In a more practical sense, at first glance, the choice of place of abode, particularly regarding health care decisions, would seem to be a power more appropriate for a health care agent. But the court in *In re Julia C.* gives the practitioner pause before relying on a health care proxy for such authority.[13]

> Section 2982(l) of the Public Health Law give the health care agent the authority to make any and all health care decisions on the principal's behalf that the principal could make. A health care decision is defined as any decision to consent or refuse to consent to health care [defined as 'any treatment, service or procedure to diagnose or treat an individual's physical or mental condition']. Public Health Law 2980(4), (6). The fact that a health care proxy exists does not, in itself, always obviate the need for a guardianship. Public Health Law 2992. The scope of Article 81 of the Mental Hygiene Law and Article 29-c of the Public Health Law do not overlap with respect to making decisions regarding the social environment and other such aspects of the life of the incapacitated person and choosing her place of abode. Mental Hygiene Law 81.22(2) and (9). Article 29-c of the Public Health Law is very specific—it is health care treatment related. While treatment may be ancillary to placement (i.e. skilled nursing care), the agent under a health care proxy is not afforded the same authority over an individual as a personal needs guardian, who is subject to Court scrutiny.[14]

The Court's decision, read in full, seems to suggest that *only a guardian* has the authority to choose another's place of abode, particularly given the "subject to Court scrutiny" declaration made by the court.[15] However, a synthesized reading of the power of attorney statute, and the *In re Julia C.* decision, leaves open the possibility for a principal of a statutory short form power of attorney to give its agent the power to choose the place of abode in the modifications section. Additional case law, as expounded up below, supports this argument.

III. Broad Authority of Agent, but Limitations Abound

Pursuant to MHL article 81.22(a)(2), a guardian may be granted the power to "make decisions regarding social environment and other social aspects of the life of the incapacitated person."[16] In *Perosi v. LiGreci* the Appellate Division, Second Department noted that "[g]enerally, the scope of a power of attorney is limited only by the boundaries of the principal-agency relationship," with exceptions.[17] The court opined that the "exceptions include, but are not limited to: the execution of a principal's will... the execution of a principal's affidavit upon personal knowledge...or the entrance into a principal's marriage or divorce...".[18] Indeed, some decisions are so personal that neither an agent under a power of attorney *nor a court-appointed guardian* could be granted decision-making authority, such as divorce.[19] In *Arens v. Shainswit* the Appellate Division, First Department opined that:

> The General Obligations Law codifies as the public policy of this State that there be liberal use and judicial recognition of the efficacy of powers of attorney and further states that the general authority with respect to "all other matter" authorizes the agent to act as alter ego of the principal with respect to any and all possible matters and affairs. (General Obligations Law, §§ 5-1501, 1502 L.)[20]

However, the court in *Arens v. Shainswit* qualifies this rule by holding that there are powers that are "so peculiarly personal that delegation is forbidden."[21] In the end, the general rule, consistent with the holding in *Perosi v. LiGreci*, is that a power affirmatively delegated to an agent by a principal in the modifications section of a statutory short form power of attorney is valid *and* will generally obviate the need for guardianship. This is especially true since the public policy of New York State from 1993 on is to require judicial recognition and approval of the plan an individual has made for the management of his or her property and personal needs, and *not* to impose a guardianship if that plan meets the needs of the individual.[22]

IV. Conclusion

The statutory short form power of attorney provides a broad range of default powers in paragraph "O," but estate planning and elder law attorneys would be wise to add additional provisions to the modifications section, in consultation with the client, of course, that could further protect the principal-client from guardianship, i.e., a provision authorizing the agent to choose the place of abode or make decisions regarding social environment

and other social aspects of the life of the incapacitated person. This is consistent with the policy that an agent is a principal's alter ego, and the policy that guardianship is a last resort.[23]

Endnotes

1. *In re Julia C.*, N.Y.L.J. March 15, 2004, p. 17, col. 3 (Nassau Co. Ct.).
2. *Id.*
3. *Id.*
4. *Id.*
5. Now paragraph "N."
6. *In re Julia C.*, N.Y.L.J., March 15, 2004, p. 17, col. 3 (Nassau Co. Ct.).
7. MHL art. 81.22.
8. *In re Julia C.*, N.Y.L.J., March 15, 2004, p. 17, col. 3 (Nassau Co. Ct.).
9. *Id.*
10. GOL § 5-1503.
11. GOL § 5-1503(3).
12. GOL § 5-1502G(10).
13. *In re Julia C.*, N.Y.L.J., March 15, 2004, p. 17, col. 3 (Nassau Co. Ct.).
14. *Id.*
15. *Id.*
16. MHL art. 81.22(a)(2).
17. *Perosi v. LiGreci*, 98 A.D.3d 230, 238 (2d Dep't 2012).
18. *Id.* at 237.
19. *Mallory v. Mallory*, 113 Misc.2d 912, 915 (Sup. Ct., Nassau Co. 1982); *In re Irving Wechsler*, 3 A.D.3d 424 (1st Dep't 2004).
20. *Arens v. Shainswit*, 37 A.D.2d 274, 279 (1st Dep't 1971).
21. *Id.*
22. *In re Estate of Murray*, 14 Misc.3d 591, 599 (Sur. Ct., Erie Co. 2006).
23. *In re Julia C.*, N.Y.L.J. March 15, 2004, p. 17, col. 3 (Nassau Co. Ct.).

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New York NAELA Niche: The Social Security Administration Releases the POMS on SNTs…Finally!!!

By Robert P. Mascali

Robert P. Mascali

On April 30, 2018, the Social Security Administration (SSA) released its long awaited update on the Practice Operations Manual System (POMS) related to special needs trusts. The update has been anticipated for some time, ever since a number of advocates in the field of special needs planning requested clarity from SSA on a number of points—many, but not all of which, are covered in this update. However, by any standard this update represents a major policy revision on the issue of special needs trusts and it is essential that practitioners in the field have an understanding of these revisions in order to be able to properly advise their clients.

For those new to the field of special needs planning, the POMS is an internal document for use by staff of the Administration. The POMS is a primary source of information used by Social Security employees to process claims for Social Security benefits. The public version of POMS is identical to the version used by Social Security employees except that it does not include internal data entry and sensitive content instructions.

On the website of the Social Security Administration there is a note that the version on its site is intended for SSA employees and it contains technical terms and instructions, but that there is also available the Social Security Handbook, which is written in plain language for use by the public.

The revisions are contained in four separate releases, all of which are titled as *Identifying Resources* and are contained at SI 01120 TN 51 through and including SI 01120 TN 54. It would be a daunting exercise for anyone to wade through the 133 pages of the release but thankfully the SSA introduces each of the four releases with a specific notation as to Background and Summary of Changes.

In summary, the revision provides clarification on the following subjects:

1. What types of payments can and cannot be assigned to a special needs trust;
2. Certain exceptions to the "sole benefit rule" for third party payments from a special needs trust and who or what constitutes a "third party";
3. The point in time at which a person must be "disabled" for purposes of being able to establish or have established a special needs trust or pooled trust;
4. The proper manner by which a court order can create a special needs trust or pooled trust account as set forth in a number of specific examples;
5. A new policy covering the recently enacted Special Needs Fairness Act which now permits a disabled individual who possesses the requisite capacity to establish his/her own special needs trust;
6. Specific mention of allowable and prohibited expenses from a first party self-settled special needs trust and from a pooled trust account under Section 1917(d)(4)(A) and (C);
7. An expansion of the 90-day rule during which a special needs trust can be modified so as to comply with then current policy;
8. Policy direction dealing with family caregivers.

SI 01120 TN 51

In general, this section of the POMS deals with the determination and documentation of the resource status of third party trusts or trusts established prior to January 1, 2000 for Supplemental Security Income (SSI) purposes:

Summary of Significant Changes

1. Added Indian Gaming Regulatory Act (IGRA) Trusts under trust that contain assets of third parties;
2. Added definitions for IGRA, pooled and special needs trusts;

3. Clarified that SSI payments cannot be legally assigned and do not count as income for SSI purposes, thereby defeating attempts to avoid income counting by assigning SSI payments to a trust;

4. Clarified that court-ordered assignments of payments such as child support and alimony paid directly to a trustee or to a trust are considered to be irrevocable and therefore not income to the individual. Similar treatment is afforded to payments under a U.S. Military Survivor Benefit Plan (SBP) because the annuity payment is irrevocable.

SI 01120 TN 52

In general, this section of the POMS provides instruction in determining the resource status for trusts established with the assets of an individual after January 1, 2000 and clarifies the three exceptions to the "sole benefit" rule for third party payments. Specifically, SSA updated this section to clarify which payments to third parties for travel expenses do not run afoul of the sole benefit rule, which had been a cause of much concern prior to this clarification.

Summary of Significant Changes

1. Clarified the three exceptions to the sole benefit rule for third party payments by providing detailed explanations for each exception, specifically

   a. Payments to a third party that result in the receipt of goods or services by the trust beneficiary:

      i. Specifies that goods or services must be for the primary benefit of the trust beneficiary but that some collateral benefit to other parties may be permissible such as others living in a house or watching a television where the trust has made the purchase;

      ii. Discusses purchased goods that require registration or titling, such as a car or house, and that absent a prohibition in state law requires the beneficiary to be the titled owner;

      iii. Allows for a family member to be a third party service provider, the same as for a non-family member or professional service company;

      iv. Permits payment for companion services, including to a family member, and also allows for incidental expenses for the companion to be a permitted expense such as admission to a museum;

      v. Cautions against (a) requiring evidence of medical training or certification for family members who are paid caregivers, (b) requesting income tax information or similar evidence from a service provider to establish a business relationship, or (c) routinely questioning the reasonableness of a service provider's compensation.

   b. Payments of third party travel expenses to accompany the trust beneficiary and provide services or assistance that is necessary due to the trust beneficiary's medical condition, disability or age, specifically

      i. Travel expenses are transportation, lodging and food;

      ii. Providing services or assistance because of age means the trust beneficiary is a minor and cannot travel alone;

      iii. Absent evidence to the contrary, all that is necessary is a statement from the trustee that service or assistance to travel is necessary and cautions against requiring a physician's statement or that medical training is required for the accompanying person;

      iv. Directs the use of a reasonableness standard as to the number of persons needed to accompany the trust beneficiary and offers the example of a violation of the sole benefit rule if two parents expect payment for other children because the parents cnnot afford the extra cost or cannot leave them at home.

   c. Payment of third party travel expenses to visit a trust beneficiary, specifically that the travel expenses are incurred **to ensure the safety or medical well-being of the trust beneficiary,** giving two separate examples—one dealing with a service provider overseeing living arrangements when the beneficiary is living in an institution or similar supported living arrangement and the other for travel for a trustee or other fiduciary to exercise his or her fiduciary duties where the beneficiary does not reside in an institution.

2. Clarified that trust distributions to a personal debit card in the name of the trust beneficiary are the same as cash disbursements but specifically specified that "administrator-managed" prepaid cards could be an acceptable alternative provided that the trustee is considered the owner of the prepaid card account under the specified rules. For apparently

the first time, the SSA specifically mentioned a private product, in this case the True Link card, as a type of restricted debit card that can be customized to block certain transactions.

3. Added a new subsection dealing with Post-eligibility Changes in Trust Resource Status and in particular when and how to utilize the permitted 90-day amendment period in the instances where due to a change in policy clarification, or the reopening of a prior erroneous determination, a trust was previously determined **not to be** a resource is now determined **to be** a resource or ***vice versa.***

TN 01120 TN 53

In general, this section of the POMS provides the requirements for exceptions to counting assets in trusts established with the trust beneficiary's assets on or after January 1, 2000 and also incorporates a previously issued policy dealing with the establishment of special needs trusts by an order of a court. It also restates the requirement that the trust beneficiary must be disabled at the time the special needs trust is established and provides important information on the policy change as it applies to a disabled individual who is now permitted to establish his or her own special needs trust.

Summary of Significant Changes

1. Established for the first time distinct sections on Special Needs Trusts and on Pooled Trusts;
2. Clarified again that a third party can be a family member, a non-family member or an entity;
3. Clarified that the trust beneficiary must be disabled at the time the trust is established;
4. Expanded on the manner by which special needs trusts and pooled trusts can be established by court orders and provides examples for clarification of different scenarios;
5. Added a new policy on implementing the Special Needs Fairness Act which allows individuals to establish their own special needs trusts and qualify for the exception for resource counting that would otherwise be applicable;
6. Added a new subsection dealing with "Allowable" and "Prohibited" expenses for both Special Needs Trusts and Pooled Trusts prior to reimbursement of the State(s) for medical assistance:
   a. Allowable expenses are taxes due from the trust for state or federal taxes because of the death of the trust beneficiary and reasonable fees for the administration of the trust estate including an accounting and actions necessary for the termination of the trust;
   b. Prohibited expenses are specified as follows:
      - Taxes due from the estate of the beneficiary other than estate taxes;
      - Inheritance taxes for residual beneficiaries;
      - Payment of debts owed to third parties;
      - Funeral expenses; and
      - Payments to residual beneficiaries.
   c. Clarifies that for purposes of medical assistance reimbursement, a pooled trust is not considered to be a residual or remainder beneficiary and that a pooled trust has the right to retain funds upon the death of the beneficiary.
   d. Clarifies that these allowed and prohibited examples apply upon the death of the trust beneficiary and that the payment of fees and administration expenses during the lifetime of the beneficiary are governed by the terms of the applicable trust.
7. Created a new subsection dealing specifically with "Miller Trusts" under Section 1917 (d) (4) (B) of the Social Security Act. NOTE: These types of trusts are generally inapplicable for New Yorkers because of the manner in which New York permits excess income to be deposited into pooled trusts and used for appropriate monthly living expenses of the trust beneficiary

SI 01120 TN 54

In general this section discusses the procedure for the development and documentation of trusts established on or after January 1, 2000 and now clarifies the procedure regarding the review of pooled trusts for SSI purposes, including guidelines to establish pooled trust precedents, and incorporates the emergency message published by SSA on February 12, 2016 on "Guidelines on Reviewing and Establishing Pooled Trust Precedents." While of keen interest to the various pooled trust organizations doing business in New York, this transmittal will not be of particular importance to the special needs practitioner and therefore a detailed review is omitted for this article.

So Now What??

It will, of course, take time for these important changes to be fully examined and implemented. Over the course of the next few months there will no doubt be

much discussion of these changes and opportunities for practitioners to attend webinars and CLE presentations in order to become more familiar with them, and it is recommended that attorneys follow up on this brief overview of these new transmittals. That being said, there are still some actions attorneys should consider taking in the very near future to assist their clients both prior, current and future:

1. Contact clients for whom you have drafted and executed special needs trusts;
2. Advise clients as to the need to amend certain special needs trusts in order to comply with the new POMS;
3. Review office templates and revise as necessary to comply with the new POMS; and
4. Alert known beneficiaries and trustees as to the changes contained in the new POMS.

Robert Mascali is an attorney with over 40 years' experience in the nonprofit, government and private sectors. He is currently a senior consultant with The Centers, a national organization that administers special needs trusts and Medicare Set Aside Arrangements throughout the United States. In addition, Mr. Mascali is admitted to practice before the courts in the Commonwealth of Massachusetts and the State of New York and is currently "of counsel" with Bourget Law Group in Falmouth, Massachusetts and with Pierro, Connor and Associates, LLP in Latham, New York.

Mr. Mascali concentrates in the areas of Special Needs Planning for persons with disabilities and their families and caregivers, Long-Term Care Planning, and Elder Law and Estate Planning. He is a member of the New York State Bar Association and the Elder Law and Special Needs Section and the Trusts and Estates Section. He serves on the Executive Committee and is the Section's liaison to the National Academy of Elder Law Attorneys (NAELA). He is also a member of Massachusetts NAELA and is the Past President of the New York Chapter of NAELA. Mr. Mascali is a member of the Academy of Special Needs Planners and is a frequent presenter and author on topics dealing with elder and special needs law and planning.

Committee Spotlight: Special Education Committee

NYSBA Elder Law and Special Needs Section Committee 2018 Update

By Adrienne Arkontaky

Several years ago, Fran Panteleo, the Chair of our Section at the time, approached me about the possibility of forming a new committee focused on educating the membership on the protections available under the law for students with special education needs. I was excited about forming this new committee and providing information on this important and growing practice area. I believe there is an important synergy between special education law and both elder law and special needs planning.

I also believe that if elder law and special needs planners want to provide a holistic approach to planning, a basic understanding of the various special education and civil rights protections is crucial. Many of the families who come in for consultations and/or retain our services have loved ones with special education needs and struggle to navigate a complex special education system. The special needs/elder law planner's ability to at least identify special education issues is an important added value to the representation. In addition, the committee is here to guide members who might be interested in adding special education representation to their practices.

Since its inception, members have participated in several CLEs, various conferences, and held calls to establish an agenda for the year. There was be a presentation at the Summer Meeting on "Terms and Acronyms Used in Special Education." For more information on joining the committee, please contact Adrienne Arkontaky at aarkontaky@cuddylawfirm.com.

Special Invitation to the Fall Meeting 2018 from Chair Judy Grimaldi

Theme: Addressing the New Economics of Aging and applying it to your Practice.

The annual Fall Meeting of the ELSN, to be held on October 4 and 5, 2018 in scenic Park Ridge NJ, will be an innovative look at how the aging of our country is affecting our society and our area of practice. This one and a half day program tackles complex policy and practice issues facing today's Elder Law and Special Needs Attorneys across New York State. Sessions will offer a broad perspective on national socioeconomic trends in health care delivery, technology, housing, taxation, and wealth transfer—creating forum to develop adaptive practices to meet these challenges. The overarching conference goal is to promote forward thinking and opportunities to evaluate the practice of law in the broader context of our changing society.

The site of the meeting is the newly renovated Park Ridge Marriott at 300 Brae Boulevard in Park Ridge, New Jersey, conveniently located just north of the George Washington Bridge and is adjacent to the Hudson Valley, a short drive south of the Village of Nyack. This site is accessible to both upstate/downstate practitioners while providing an ideal locale for autumn leaf peepers and apple pickers without the hustle and bustle of some of the surrounding areas. Plan to enjoy an elegant dinner at the Ramsey Country Club on Thursday evening.

Our program will feature several thought provoking topics including an enlightening study on the financial challenges facing baby boomers who are retiring without pensions by social economist, Professor Anthony Webb of the New School of Social Research. Professor John Jacobi of Seton Hall Law School, our luncheon speaker, will talk about Medicaid's biases and the impact on minority applicants, especially African Americans (diversity credit). Our chairs Moriah Adamo and Mary Fern Breheney have organized a debate on the Aid in Dying Legislation for our ethics credit.

Other topics of interest:

- A Housing Options Panel
- Drafting With Social Change And Technology In Mind
- Addressing Financial Abuse Issues In Article 81 Proceedings
- A Deep Dive Into Pensions, Social Security And Qualified Plans
- Medicaid Updates and Transfer of Asset strategies
- Experts Panel of Experience Elder Law Practitioners, Lee Hoffman, Nancy Burner and Hyman Darling.

This is a packed and worthwhile agenda, I hope you will attend. Look for upcoming registration information from NYSBA!

Thursday And Friday, October 4 & 5, 2018 | Park Ridge Marriott | 300 Brae Blvd | Park Ridge, NJ

Other upcoming Elder Law and Special Needs Section Programs

Probate & The Administration of Estates 2018

Wednesday, September 26th | 9:00 a.m. - 5:00 p.m. | Albany
Wednesday, September 26th | 9:00 a.m. - 5:00 p.m. | NYC
Tuesday, October 2nd | 9:00 a.m. - 5:00 p.m. | Long Island
Wednesday, October 3rd | 9:00 a.m. - 5:00 p.m. | Buffalo
Wednesday, October 3rd | 9:00 a.m. - 5:00 p.m. | Syracuse
Wednesday, October 3rd | 9:00 a.m. - 5:00 p.m. | Westchester
Wednesday, October 10th | 9:00 a.m. - 5:00 p.m. | Rochester

Intermediate Elder Law 2018

Tuesday, October 30th | 9:00 a.m. - 5:00 p.m. | Albany
Friday, November 2nd | 9:00 a.m. - 5:00 p.m. | Westchester
Monday, November 5th | 9:00 a.m. - 5:00 p.m. | NYC
Wednesday, November 7th | 9:00 a.m. - 5:00 p.m. | Buffalo
Wednesday, November 7th | 9:00 a.m. - 5:00 p.m. | Long Island

Article 81 of the Mental Hygiene Law

Tuesday, December 4, 2018 | 9:00 a.m. - 5:00 p.m. | NYC
Wednesday, December 12, 2018 | 9:00 a.m. - 5:00 p.m. | Albany

Save the Dates for the 2019 Annual Meeting!

January 14 to 19, 2019 | New York Hilton Midtown | 1335 Avenue of the Americas | New York City

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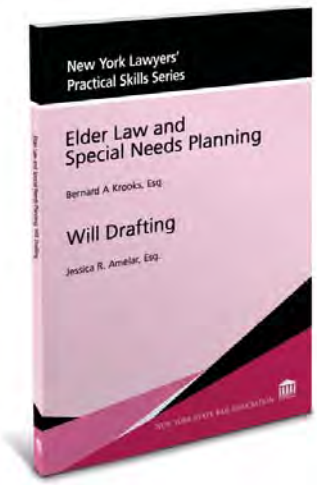

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This practice guide is currently divided into two parts.

Part One, written by Bernard A. Krooks, Esq., examines the scope and practice of elder law in New York State, covering areas such as Medicaid, long-term care insurance, powers of attorney and health care proxies. Elder law cuts across many distinct fields including benefits law, trusts and estates, personal injury, family law, real estate, taxation, guardianship law, insurance law and constitutional law.

Part Two, written by Jessica R. Amelar, Esq., gives the attorney a step-by-step overview of the drafting of a will, from the initial client interview to the will execution. This section provides a sample will, sample representation letters and numerous checklists, forms and exhibits.

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