NYS Conference of Local Mental Hygiene Directors, Inc.

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Testimony of the NYS Conference of Local Mental Hygiene Directors
NYS Senate Committee on Mental Health and Developmental Disabilities
May 31, 2013

Senator Carlucci and Members of the Committee,

Thank you for this opportunity to address your committee. My name is Jed Wolkenbreit and I am the Counsel to the NYS Conference of Local Mental Hygiene Directors (the "Conference"). The Conference is a statutory organization established pursuant to Section 41.10 of the Mental Hygiene Law (MHL) whose only members are the Directors of Community Services (DCS) for the City of New York and the 57 other counties in New York State. As you know, Article 41 of the MHL requires each local government to establish a subdivision known as the local governmental unit (LGU) to act as the policy making arm of local government in the areas of mental health, developmental disabilities and chemical abuse. It is the Conference's role to act as the statewide spokesperson for these local governmental units.

On January 15, 2013 Governor Cuomo signed into law the New York Secure Ammunition and Firearms Enforcement Act, commonly referred to as the SAFE Act. Section 20 of this law adds a new section 9.46 to the mental hygiene law which requires that when a Mental health professional (defined in the statute as a physician, psychologist, LCSW or registered nurse) who is currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall report the name of that person to the Director of Community Services. The director then must agree or disagree with the report and if he or she agrees, the DCS (or a DCS designee) is required to send the name and certain other non-clinical identifying information to the Division of Criminal Justice Services to be entered into a database for purposes of either suspending or revoking that person's gun permit or ultimately preventing that person from receiving a gun permit.

As you know there is no specificity in the statute as to how this procedure was intended to be implemented nor was any money appropriated to implement it. On January 15, 2013, local governments were told that we had 60 days to implement this system and that we would be given no extra resources to do so. Initially it was assumed that there would be 58 different systems of reporting throughout the state. Fortunately SOMH worked with the Conference to develop what has become the Integrated SAFE Act Reporting System (ISARS) portal which created a single system for all mental health professionals to use in order to file a 9.46 report. ISARS went live in an abbreviated form on March 16th and continues to be in a state of development. The ISARS system requires the reporter to give enough personal

identifying information so that a determination can be made that the person is in fact an authorized reporter. It also allows the MHP reporter to give enough clinical information so the DCS can either agree or disagree that the person being reported meets the criteria set forth in the statute and should be reported on to DCJS. Much credit is due to the IT team at SOMH for this accomplishment.

As we read the statute a DCS needs to be assured of 4 major elements before passing on a report:

(i) The report must be made by a person defined as a mental health professional (MHP) under the statute.

(ii) The DCS must be satisfied that the mental health professional has independently exercised reasonable professional judgment.

(iii) The MHP must have determined that the patient is likely to engage in conduct which would result in serious harm to self or others and must provide sufficient information so that the DCS can confirm this determination.

(iv) The MHP making the report must be currently providing treatment services at the time the determination is made.

If any one of these criteria is not present we believe that the law requires the DCS to "disagree" with the report and not pass it on to DCJS.

As Counsel to the Conference, much of my time for the last 2 and ½ months has been spent dealing with the questions and concerns of the DCSs throughout the state concerning this new law, so let me share a little of what is happening on the local level. Since March 16th there have been over 5,000 reports made through the ISARS system with about 2/3rds of those coming from the New York City. The vast majority (over 92%) of the reports is coming from hospitals, primarily Article 28 hospital emergency departments and psychiatric units; although more recently the State operated psychiatric centers have filed about 1,000 new reports in bulk into the system. A very small percentage (about 5%) of the 9.46 reports is coming from outpatient providers and a relatively insignificant number are being received from private practitioners. Until recently DCSs have passed on to DCJS over 90% of the reports that they received. More recently several issues have come to our attention which are troubling and have made many DCSs very skeptical about the reports that are being received.

Those problem areas include:

1. Some DCSs are receiving reports that appear to be made by someone other than the MHP treating the patient. This might be a person designated by the hospital to make such reports or in some cases by a computer generated report. Technically such a report is neither made by an MHP who is currently treating the

subject nor is it based on reasonable professional judgment. In many cases when the DCS or their designee have called the noted reporter to confirm, they are being told that he or she did not file the report or that the subject of the report does not meet the criteria of 9.46.

2. It is troubling to many of our members that we have been advised that the State has taken the position that **all persons** admitted to a State Psychiatric Center meet the criteria of 9.46 simply by virtue of their admission and, for at least some period of time, all such admitted persons were apparently being reported en mass by computer generated reports not based on the reasonable professional judgment of a treating clinician as the statute requires. This is totally inconsistent with SOMH's published guidance to Mental Health Professionals which states that "… a person could meet the "2 PC" standard, but still not pose a risk of harm that justifies action pursuant to either the emergency removal … or the 9.46 standard." Groups representing Article 28 hospitals have indicated to us that they are also concerned with this procedure and agree that not all persons admitted for mental health treatment meet the criteria for 9.46 reporting.

   Columnist David Brooks expressed the importance of the need for a hands on approach very well in his NYT column earlier this week when he said "The best psychiatrists are not austerely technical; they combine technical expertise with personal knowledge. They are daring adapters, perpetually adjusting in ways more imaginative than scientific rigor." Determining whether someone might in the future be "dangerous" cannot be determined by a blood test or an x-ray; it requires the "reasonable professional judgment" of a trained professional.

3. We are advised that in some cases, based on potential risk management standards, hospital administrators or hospital counsel have recommended or required that all persons admitted to hospitals with a mental illness diagnosis be reported under section 9.46. In passing on a 9.46 report a DCS must make a judgment which involves weighing an invasion of a person's civil rights against the legitimate need to protect the public. The statute requires that this judgment be based on the "reasonable professional judgment" and should be made on a case by case basis by a trained professional who is treating a person. Someone being admitted to a hospital based on their inability to care for themselves due to mental illness or for medication management is not in most cases "likely to engage in conduct

which is dangerous to self or others." But under this wide net approach they would be reported to the DCS. The DCS is then put in the difficult position of having to either spend a great deal of time investigating each report or assuming the validity of reports from the ISARS portal and passing it on. In some cases the numbers of reports are just too staggering for any independent evaluation to occur so the DCS is required by reality to accept the validity of the ISARS reports. Some DCSs are concerned that in such cases it is possible that persons who do not meet the requirements of the statute are being reported on to DCJS but without adequate resources from the State there is little they can do.

4. The statute as written contains no specification regarding the age of a patient to be reported. Recently, DCSs have begun receiving numerous reports, primarily from State hospitals, which involve children who are as young as 11 years old. Upon investigation we determined that SOMH is requiring **all** of its hospitals and advising all Article 28 hospitals to report all admissions of children 11 years of age or older. We are told this is because it is theoretically possible for a 16-year-old to enter military service with parental consent and also to be honorably discharged at age 16, and then apply for and be granted a gun permit. Reporting 11 year old patients would mean their name might still be in the data base when they reach age 16. Many members of the Conference feel that placing the name of an 11-year-old emotionally disturbed child into a criminal justice database is, in and of itself, unconscionable; but to determine that the benefit of the unlikely possibility that there might be a 16-year-old who had been emotionally disturbed at age 11 and then managed to enlist in the military at 16 getting a gun permit is more important than the future of an 11 year old child in the care of SOMH really defies logic. The Conference has written to Commissioner Woodlock outlining these issues and we expect to be meeting with her and her staff in the near future to discuss and hopefully resolve these issues.

5. Another major problem is the amount of time and resources that the SAFE Act is diverting from all of the other duties of the DCS for what we believe to be a minimal return. In the larger LGUs the numbers of 9.46 reports that are already being submitted are diverting a great deal of time and energy away from an already overburdened staff. In larger communities such as New York City the number of reports being filed (about 1,000 per month) makes it impossible to investigate each report. In some of the other larger cities in the State the numbers of reports are in the

range of 50-100 per week or more. Given that each person applying for a gun permit must already undergo an investigation which includes a determination as to whether "he or she has ever suffered any mental illness or been confined to any hospital or institution, public or private, for mental illness", the information gathered in these 9.46 reports should also surface at the time of application for a permit and could be determined at the time of renewal so we sincerely question why mental health treatment resources, which are already scarce, are being diverted to this new task.

Finally as a lawyer and former counsel to a legislative committee on Mental Health I cannot close without at least pointing some problems that I perceive with the law as written:

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- The law defines Mental Health Professionals as including all physicians and registered nurses and does not requires that the MHP actually be treating the subject for a mental illness. As the law was written any physician who is treating any patient for any reason and who determines that the patient may be likely to engage in conduct which would cause harm to self or others should be reported. Theoretically a dermatologist who is treating an 11 year old for acne and is told by the patient that "I hate my skin so much I could kill myself" could be required to file a 9.46 report under this statute. This of course makes no sense.

- The law does not say that the likelihood of danger must be imminent. All of the other provisions of Article 9 of the Mental Hygiene Law that allow the limitation of another's freedom require that there be some immediate danger to self or others. Here the standard is "likely to engage in conduct which would result in harm to self or others". Does that mean tomorrow, next week or next year? The Court of Appeals has held that ..." the fact of mental illness (does not) result in the forfeiture of a person's civil rights." The courts will have the final say of course but I question whether placing someone's name in a criminal justice database based on the SAFE Act standard meets that test... Especially when that person is 11 years old.

- The statute specifically limits liability for the MHP with regard to reporting but there is no such limit on liability for the DCS or local government making reporting decisions in good faith.

- And finally from the point of view of local government section 9.46 is an **unfunded mandate** of a growing and potentially disastrous magnitude, for

which localities are neither equipped nor funded to implement. If the statute's intent is simply to gather names, then why have the DCS involved in the process at all. If the intent is to really clinically assess each of these reports then either that should be done by a state agency or substantial resources should be allocated to local governments to do it. Since all gun permit applications currently require an investigation into the mental health of the applicant, perhaps a more thorough investigation limited to persons actually seeking permits or renewals of permits would better meet this goal so that it would not be necessary to cast this wide net which appears to criminalize people suffering from mental illness and increases the very stigma which we all are trying so hard to decrease.

On behalf of the Conference of Local Mental Hygiene Directors, I want to thank you all for your efforts on behalf of the mentally disabled persons of this state who depend on all of us to help them go forward toward recovery and for the opportunity to share the Conference's views and perspectives on the SAFE Act with you today. As always the Conference remains available to you as a resource as you continue your work.