NYS Conference of Local Mental Hygiene Directors, Inc.

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Memorandum in Opposition

S.4722 (Young)/A.1275 (Gunther)

AN ACT to amend the mental hygiene law and the correction law, in relation to enhancing the assisted outpatient treatment program; and to amend Kendra's Law, in relation to making the provisions thereof permanent

The New York State Conference of Local Mental Hygiene Directors (the Conference) **strongly opposes S.4722/A.1275** which makes significant changes to the New York Assisted Outpatient Treatment law.

The Conference was established pursuant to Article 41 of the Mental Hygiene Law and is comprised of the Directors of Community Services (DCS) for the 57 counties and the Department of Mental Hygiene for the City of New York. The DCS is commonly known as the County Mental Health Commissioner. The DCS is responsible for the Assisted Outpatient Treatment (AOT) program in their Local Governmental Unit (LGU).

Chapter 408 of the Laws of 1999 creates a statutory framework for court-ordered Assisted Outpatient Treatment (AOT), to ensure that individuals with mental illness and a history of hospitalizations and difficulties following a treatment plan participate in community-based services appropriate to their needs. The law attempts to ensure that services are received by those consumers least likely to pursue them and most likely to be dropped from other services because they present a unique challenge. This law establishes a procedure for obtaining court orders for certain individuals with mental illness to receive and accept outpatient treatment which strikes a careful balance between protecting the constitutional rights of the patient and the interests of the community. Our members are in a unique position to judge the effectiveness of AOT since it is our members, the Directors of Community Services, who are charged with the front line duty of helping to create and oversee the treatment plans which are the backbone of the law. We strongly disagree with the significant changes that this bill seeks to make; some of which we feel could invalidate the entire law as unconstitutional. We also see no reason to make the AOT law, which is not due to sunset until June 30, 2017, permanent at this time.

In addition, this legislation imposes **substantial unfunded mandates on localities and the state** in several ways. This bill lays the foundation for runaway costs across the program by establishing a presumption that AOT orders should be initiated and/or indefinitely continued in the absence of a proactive reversal of this presumption. The bill would significantly increase costs to the LGUs in their local oversight of AOT orders, the State with increased program coordinator caseloads, and the local court systems which will be required to address countless new AOT petitions that could be filed by members of the community at large, with the assistance of the newly required petitioner assistance program created under the proposed 9.60(f)(2). The creation of this assistance program itself, and the bill's additional requirement that all petitions filed by family or members of the community (among others) be subject to additional OMH rulemaking to "ensure" the filing of an AOT petition when appropriate not only creates new programmatic elements to AOT but

imposes additional burdens of legal liability to the DCSs who would be required to demonstrate why they *are not* pursuing a petition, rather than why they are. The local DCS already has the ability to investigate reports from family members and there is no need for additional language circumscribing their authority.

Some of the changes this bill seeks to effect do not make sense and may be unconstitutional.

1. The bill seeks to amend Mental Hygiene Law (MHL) 7.17 (f) to require that AOT program coordinators monitor local programs concerning expiring AOT orders which fundamentally changes the role of the program coordinator from one of monitoring and oversight to one of operational responsibility. Currently health care professionals make these decisions on the local level. This change would mean that a State employee without having seen the patient would be overseeing clinical decisions made by health care professionals on the local level. We strongly oppose any such usurpation of local clinical decision making as both bad policy and bad medicine.

2. The bill seeks to require that a Director of Community Services' responsibility to investigate reports of persons who may be in need of AOT applies to reports received from family and community members, as well as reports received from hospital and correctional facility directors. This requirement appears to give family members and even social acquaintances, whose motivation may not be the best interest of the patient, statutory authority to limit the professional discretion of the DCS. Mental Illness often causes dysfunction in families and social relationships, and DCSs currently receive such reports and have the discretion to and do investigate as deemed appropriate.

3. The bill would also require the development of an assistance program for any community members or family in pursuit of an AOT petition, requiring the Office of Mental Health to promulgate regulations to facilitate such assistance. This proposal is not specific to whether such program would be imposed to counties or to the State; either way would be an unfunded mandate. OMH would also be required to promulgate regulations that would "ensure" the timely review and filing of an order "when appropriate" of such petitions from family and members of the community at large (among others). Both of these provisions create additional mandates and further erode local and clinical authority over the program. The bill language is also unclear as to who has the authority to determine when it is appropriate to seek an order.

4. The bill seeks to amend MHL 9.48 to require that AOT program directors' quarterly reports to program coordinators include information on any expired AOT court orders, including the determination made as to whether to petition for renewal, the basis for such determination, and the court's disposition of the renewal petition. This would almost create a statutory presumption in favor of AOT extensions without showing any clinical need or value. It once again requires the program coordinator to second guess clinical decisions by local health care professionals. Since the renewal decision is solely within the county's discretion, there is no point to this provision other than to create conflict without benefit, and it will ultimately be a disincentive to original AOT petitions.

5. The bill seeks to add medication or symptom management training, financial management services, and representative payee services as listed potential services to be included in AOT and specifies that other services which may be included in an individualized treatment plan need not be clinical in nature. This results in two problems. Local mental hygiene departments are simply not in a position to offer non clinical services such as financial management training to AOT patients. The second is the legality. If the recipient is in need of an Article 81 guardianship then that is the correct proceeding. Attempting to bypass the criteria of Article 81 in an AOT order presents constitutional issues. As the Court of Appeals stated in Matter of K.L., "(t)he determination by a court that a patient is in need of assisted outpatient treatment shall not be construed as or deemed to be a determination that such patient is incapacitated pursuant to article eighty-one" of the Mental Hygiene Law.

6. The bill attempts to create a major unfunded mandate on the locality by requiring the DCS to receive and investigate reports by hospital directors discharging patients who were initially admitted on an involuntary basis

in cases when the hospital director does not petition for an AOT order upon release and also requires DCS investigation of AOT need for inmates released from hospitals serving prisoners with mental illness. AOT has been regularly used as part of discharge planning since its inception. If the treating psychiatrist and the hospital director or the prison doctor have already determined that it is not a necessary part of the discharge planning then what purpose is served by requiring the DCS to review the same records. Furthermore, in counties with State hospitals or prisons this could result in numerous additional reviews of cases where the treating professional has already determined that the AOT order is not necessary.

7. The bill seeks to amend the statute to specifically require examining physicians to make "reasonable effort" to obtain information from the family members of the subject of an AOT petition. Again in appropriate cases a physician developing the treatment would certainly make reasonable efforts to obtain relevant information which may include family input when appropriate. This provision might require such input in every case creating rights accruing to family members which do not otherwise exist under the statute. Also it raises potential concerns about the release of protected health information in violation of HIPAA.

8. A major problem with the bill is that it establishes a **presumption** that a person with an assisted outpatient treatment order should be removed to a hospital to determine his or her need for admission merely based on his or her failure to take medication, submit to blood testing or urinalysis, or comply with drug or alcohol treatment. This creates a serious limitation on clinical judgment and essentially forces a doctor to involuntarily transport someone to a hospital even if in their clinical judgment they determine that hospitalization is not appropriate or face violating the statute. This would create a major likelihood of constitutional challenges to the statute. The Court of Appeals has held that: "If an assisted outpatient later fails or refuses to comply with treatment as ordered by the court; if efforts to solicit voluntary compliance are made without success; and if in the clinical judgment of a physician, the patient may be in need of either involuntary admission to a hospital or immediate observation, care and treatment pursuant to standards set forth in the Mental Hygiene Law, then the physician can seek the patient's temporary removal to a hospital for examination to determine whether hospitalization is required." Removal of most of those criteria clearly undermines the legislature's careful consideration of constitutional issues in the original drafting of the law.

In Matter of K.L., the Court of Appeals said "The restriction on a patient's freedom effected by a court order authorizing assisted outpatient treatment is minimal, inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives. For although **the Legislature has determined that the existence of such an order and its attendant supervision increases the likelihood of voluntary compliance with necessary treatment, a violation of the order, standing alone, ultimately carries no sanction.** Rather, the violation, when coupled with a failure of efforts to solicit the assisted outpatient's compliance, simply **triggers heightened scrutiny on the part of the physician,** who must then determine whether the patient may be in need of involuntary hospitalization." This bill seeks to substantially change that equation and we respectfully contend that no such action should be taken without very careful study of the impacts and legality of such changes.

For all these reasons the Conference **strongly opposes S.4722/A.1275**.