NYS Conference of Local Mental Hygiene Directors, Inc.

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Memorandum in Opposition

S.631 (Carlucci)/A.1823 (Gunther)

AN ACT to amend the mental hygiene law, in relation to establishing protocols for assisted outpatient treatment for substance abuse

The New York State Conference of Local Mental Hygiene Directors (the Conference) **strongly opposes** S.631/A.1823 which would establish an Assisted Outpatient Treatment Program for Substance Abuse.

The Conference was established pursuant to Article 41 of the Mental Hygiene Law, and its members are the Directors of Community Services (DCSs) for the 57 counties and the Department of Mental Hygiene for the City of New York. The DCSs are currently responsible at the local level for the operation of the Assisted Outpatient Treatment (AOT) Program for people with mental illness, established under Section 9.60 of the Mental Hygiene Law (MHL). As such, our members are in a unique position to knowledgeably evaluate the merits of this proposed legislation.

The current AOT law establishes a procedure for obtaining court orders to induce people who are mentally ill, have a history of psychiatric hospitalizations or serious violent behavior toward self or others and difficulty following a treatment plan, to adhere to a supervised outpatient treatment plan, which often includes continuing to take the appropriate medications, to survive safely in the community. This bill attempts to apply that program to individuals with substance use disorders which we believe will not work.

Under this legislation, the subject of the AOT for substance abuse is a person with at least two recent substance abuse-related hospitalizations or incarcerations, or who has a history of serious violent behavior toward self or others and difficulty following a treatment plan. If the court order is obtained, the individual would be ordered to participate in outpatient treatment. However, if the person meets the Assisted Outpatient Treatment criteria in the bill, it is likely that the person would require the higher levels of *inpatient* addiction rehabilitation or *long term residential treatment* and would not be well-served by court ordered *outpatient* treatment.

In addition, the bill provides that the only real sanction imposed on a person who refuses to follow the court order, is an action under the current section 22.09 of the Mental Hygiene Law. This section of law essentially provides for an involuntary transport by law enforcement to a hospital emergency room for a period of up to 48 hours in order for a person to have a chance to essentially "sober up" in a medical facility. Section 22.09 has been in effect for 16 years and is essentially never used by DCSs because it is

ineffective in getting a person engaged in treatment and serves only to impose a substantial burden on hospitals and law enforcement.

We believe that it would be a serious misuse of limited resources, and more importantly, creates false hope for the families of individuals with substance use disorders, to go through the weighty process of obtaining a court order, as set forth in this bill, to require a substance abuser to attend outpatient treatment which, by virtue of their disease he/she is unlikely to comply with, when there is no real sanction for their non-compliance with the order.

Aside from these policy issues, there are numerous issues with the bill as written, including:

Fiscal Impact to the Counties & New York City: The bill does not appoint who would be responsible for the oversight and operation of the AOT Program for Substance Abuse. The Conference is very concerned that the vague language leaving discretion to the Commissioner of OASAS as to who will have the ability to file a petition would in fact end up being delegated to the DCSs. However, there is no additional funding included in the bill to implement this new program. This legislation would create an enormous increase in work for the County/New York City mental health departments for a program that would have little or no benefit to people suffering from substance use disorders. The legislation would have a fiscal impact and create an unfunded mandate in several ways:

- Cost of process serving to initiate an AOT order - The bill allows an AOT petition to be filed by any roommate, parent, spouse, sibling or child of the subject of the petition, or "any other person deemed appropriate by the Commissioner in regulation." As we know from our AOT experience, very few petitions are filed by roommates or family members, as this would necessitate them engaging counsel and incurring the expense of filing the petition. Under the current AOT law for people with mental illness, most petitions are filed by the Directors of Community Services, and the County/New York City assumes the cost of serving papers to initiate AOT proceedings.
- Cost to pick up individuals – There is a cost to Counties/NYC to pick up persons with mental illness who do not comply with their current AOT order. New York City currently budgets more than $600,000 for sheriff support when individuals do not comply with their current AOT court order.
- Program oversight - If so designated by the Commissioner of OASAS to operate the program, the cost to the Local Governmental Unit (LGU) to operationalize this legislation on the local level would be considerable. If a court order is obtained, some oversight would be needed to ensure that services are provided to individuals in accordance with the court order and not just to ensure that the individual is following the treatment plan. In order to achieve this, the LGU would need to establish an operational structure to monitor providers as well as the individuals on the court orders.

Cost to individuals and insurers:

- Cost of physician services – The bill requires a written treatment plan developed by a physician who will ultimately have to testify before the court. There is a scarcity of physicians in New York who are certified in addiction medicine. Most of the rural areas have no such physician available. There is no provision in the bill as to who would pay for

these physician services, so one would presume that the roommate or relative of the subject would have to engage the services of a physician in order to develop the written treatment plan and appear in court. If the program responsibility were delegated to the DCS, physician costs would have to be paid for by the locality.

- Cost of treatment services – The bill as written does not provide for who is financially responsible for the cost of the treatment services. If the individual has commercial insurance or Medicaid coverage, court ordered treatment is generally paid for by the insurer or by Medicaid. If the individuals is uninsured, he/she or their family would likely be responsible for the cost of treatment services.

Service Capacity: If a court order is obtained, it is only as good as the services available in the community. The existing substance abuse treatment system is stretched and individuals and families are met with waiting lists for services, especially in rural counties.

HIPAA Issues: The physician would need access to medical records in order to develop a treatment plan. In the event that the subject will not voluntarily participate in the development of the treatment plan – and therefore will not provide HIPAA consent - it is virtually impossible that a treatment plan could be written. The New York State Court of Appeals held In the Matter of Miguel M. v Charles Barron that HIPAA requires that, in the absence of patient authorization, a DCS must go to court to obtain the medical records necessary to support the AOT petition. For substance abusers there would be the additional burden of the Federal Confidentiality Law (42CFR. Part 2) which may create an insurmountable burden to the petitioner.

Duplicative Advisory Council: Finally, the bill creates an Assisted Outpatient Treatment for Substance Abuse Advisory Council which would be required to meet and make recommendations to the Commissioner regarding policy, rules or regulations necessary to implement the program. While there is nothing intrinsically wrong with having an advisory council, it would seem that the expense of another advisory council is unnecessary, given that the Behavioral Health Services Advisory Council already exists and is charged with making policy recommendations.

For these reasons, therefore, the Conference **strongly opposes** S.631/A.1823.