

Kendra's LAW

Final Report on the Status of
**Assisted
Outpatient
Treatment**

New York State
George E. Pataki, Governor

Office of Mental Health
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Introduction

ON AUGUST 9, 1999, Governor George Pataki signed Kendra's Law (Chapter 408 of the Laws of 1999), creating a statutory framework for court-ordered Assisted Outpatient Treatment (AOT) to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs.¹ Kendra's Law was named in memory of Kendra Webdale, a young woman who died in January, 1999 after being pushed in front of a New York City subway train by Andrew Goldstein, a man with a history of mental illness and hospitalizations. The law became effective in November of 1999.

Since that time, the New York State Office of Mental Health (OMH) has been evaluating the impact of Kendra's Law on individuals receiv-

ing court-ordered services. In January, 2003 OMH issued an Interim Report required by Kendra's Law, which reviewed the implementation and status of AOT and presented findings from OMH's evaluation of the program.² This Final Report on the status of AOT in New York State is also statutorily required and updates the Interim Report.

Implementation of Assisted Outpatient Treatment

Kendra's Law established new mechanisms for identifying individuals who, in view of their treatment history and circumstances, are likely to have difficulty living safely in the community without close monitoring and mandatory participation in treatment. It also established mechanisms for ensuring that local mental health systems give these individuals priority access to case management and other services necessary to ensure their safety and successful community living.

Notes

- 1 Appendix 1 contains a copy of Kendra's Law. Appendix 2 contains an analysis of court decisions relating to Kendra's Law. Appendix 3 contains the Matter of K.L., the Court of Appeals decision upholding the constitutionality of Kendra's Law.
- 2 OMH's Interim Report on Kendra's Law is available on the OMH Web site at http://www.omh.state.ny.us/omhweb/Kendra_web/interimreport/

The statute created a petition process, found in Mental Hygiene Law section 9.60, designed to identify at-risk individuals using specific eligibility criteria, assess whether court-ordered outpatient treatment is required, and if so, develop and implement mandatory treatment plans consisting of case management and other necessary services.

Kendra's Law requires that each county in New York State and New York City establish a local AOT program to implement the statute's requirements, and charges OMH with the responsibility for monitoring and overseeing the implementation of AOT statewide. Implementation of Kendra's Law and AOT has been a joint responsibility and collaboration between OMH and local mental health authorities.

Eligibility Criteria for AOT

Kendra's Law contains the following summary description of the AOT target population:

"...mentally ill people who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization."

The statute further defines specific eligibility criteria, which are listed below.

An individual may be placed in AOT only if, after a hearing, the court finds that all of the following have been met. The individual must:

1. be eighteen years of age or older; and
2. suffer from a mental illness; and
3. be unlikely to survive safely in the community without supervision, based

- on a clinical determination; and
4. have a history of non-adherence with treatment that has:
 - a. been a significant factor in his or her being in a hospital, prison or jail at least twice within the last 36 months; or
 - b. resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last 48 months; and
5. be unlikely to voluntarily participate in treatment; and
6. be, in view of his or her treatment history and current behavior, in need of AOT in order to prevent a relapse or deterioration which would be likely to result in:
 - a. a substantial risk of physical harm to the individual as manifested by threats of or attempts at suicide or serious bodily harm or conduct demonstrating that the individual is dangerous to himself or herself; or
 - b. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm; and
7. be likely to benefit from AOT; and
8. if the consumer has a health care proxy, any directions in it will be taken into account by the court in determining the written treatment plan. However, nothing precludes a person with a health care proxy from being eligible for AOT.

Resources to Provide Court-Ordered Services

The Governor's budget for Fiscal Year 2005-2006 provides more than \$32 million for operation of services in support of Kendra's Law. This appropriation continues State support of

case management and other services aimed at keeping recipients in a treatment program, including psychiatric medication as required. Since Kendra's Law went into effect, Governor Pataki has also acted to expand access to case management and other key community-based mental health services that would be needed by individuals receiving court-ordered treatment, as well as many other individuals with severe mental illness who have less intensive, but still substantial, service needs. The Governor's budget for Fiscal Year 2005-2006 also provides more than \$125 million in ongoing funding for such services. This "Enhanced Community Services" funding has been used to both improve and expand the capacity of the existing community-based mental health system and to strengthen the cohesiveness and coordination of that system. More specifically, Enhanced Community Services were designed to steer the New York State mental health system toward a more person-centered, recovery-oriented service delivery approach, and were targeted for the following purposes:

- ◆ to *expand case management*, Assertive Community Treatment (ACT), and housing services to support community integration;
- ◆ to *develop Single Points of Access* (SPOA) to better manage service access and utilization; and
- ◆ to *increase the availability of other services* that enhance community participation and improve the engagement, quality of life, and satisfaction level of service recipients.

AOT Program Administration

Following the enactment of Kendra's Law in August of 1999, OMH AOT program staff developed and disseminated guidelines to counties to assure the appropriate implementation and operation of AOT statewide. In November of 1999, when the law became

effective, local governments began to operationalize their AOT programs. OMH promulgated AOT program standards in 2002 and in 2004, providing further guidance to local AOT programs.

In counties other than in New York City, the county Mental Health Directors operate, direct and supervise their AOT programs, either directly or by designation to other local mental health officials. In New York City, the Clinical Director for the New York City Department of Health and Mental Hygiene oversees implementation of the City's AOT program, which is administered by designated teams of employees of the New York City Health and Hospitals Corporation. These local AOT programs accept and investigate reports of persons who may be in need of AOT, prepare and file petitions for AOT in local supreme or county courts, and prepare and/or approve proposed AOT treatment plans. In those instances where an AOT order is granted, the Director of the local AOT program is required to provide or arrange for all categories of assisted outpatient treatment included in the order.

Local AOT programs are responsible for the oversight and monitoring of service providers, including case management services and ACT team services. It is the case management or ACT team which directly monitors the recipient's level of compliance, as well as delivery of services by other providers pursuant to the order. The case manager or ACT Team routinely report to the local AOT Program Director with respect to each recipient's treatment status.

State Oversight

OMH is responsible for statewide oversight and monitoring of the AOT Program. The OMH Statewide Director of AOT, appointed

by the Commissioner of OMH, is responsible for administering the program. Pursuant to section 7.17(f) of the Mental Hygiene Law, the Commissioner of OMH has also appointed OMH AOT Program Coordinators, who report to the Director of AOT, and who monitor and oversee operation of local AOT programs across New York State. The AOT Program Coordinators are located in each of the five OMH Field Offices in different geographic regions throughout the State, and work closely with the local AOT Program Directors in the counties in their respective region. The AOT Program Coordinators oversee and monitor the local AOT programs, provide information and support pertaining to the petition process, and support the local AOT programs in their efforts to provide or arrange for court-ordered services.

As part of its oversight and monitoring efforts, OMH has developed and implemented a system of Verification of Service Delivery. Each calendar quarter, 5% of all active AOT cases across the State are chosen randomly and a detailed review is conducted to verify that the local AOT Programs have fulfilled their service delivery obligations. For each case reviewed, OMH AOT Program Coordinators, or their staff, conduct verification visits to all service providers for the AOT service recipient, where they review medical charts and interview employees of the providers. In some instances, local AOT Program staff accompany the AOT Program Coordinator on verification visits creating even more effective coordination between service providers, and State and local AOT program officials.

Impact of AOT on Local Mental Health Systems

Counties and stakeholder groups statewide

have reported that the implementation of processes to provide AOT to individuals under court orders has resulted in beneficial structural changes to local mental health service delivery systems. New mechanisms for identifying, investigating, and assessing individuals, developed in order to fulfill the requirements of AOT, have enhanced accountability in local mental health service systems. AOT implementation has improved access to services for high need individuals, treatment plan development, discharge planning, and coordination of service planning. The implementation of AOT has also supported the development of more collaborative relationships between the mental health and court systems.

Enhanced Accountability and Improved Access to Services. AOT has been instrumental in increasing accountability at all system levels regarding delivery of services to high need individuals. Community awareness of AOT has resulted in increased outreach to individuals who had previously presented engagement challenges to mental health service providers. Local mental health systems began to identify the potential risk posed by not responding to individuals in need, and as a result, those systems improved their ability to respond more efficiently and effectively.

Improved Treatment Plan Development, Discharge Planning, and Coordination of Service Planning. Processes and structures developed for AOT have resulted in improvements to treatment plans that more appropriately match the needs of individuals who have had difficulties using mental health services in the past. AOT is designed to bring service providers and county administrators together in a collaborative attempt to most efficiently deliver appropriate services to these individuals. Case managers, ACT Team staff, other clinical service providers, county

personnel and attorneys, recipient advocates, and family members are all among the participants in AOT related service planning.

Improved Collaboration between Mental Health and Court Systems. Implementation of AOT involved the development of a petition process with specific eligibility criteria designed to identify at-risk individuals, prompted novel legal issues, and required greater interaction between the court system and the community mental health services delivery system. As AOT processes have matured, professionals from the two systems have improved their working relationships, resulting in greater efficiencies, and ultimately, the conservation of judicial, clinical, and administrative resources.

In addition to these improvements, consultations with officials of local AOT programs have identified the following improvements in collaboration:

- ◆ There is now an organized process to prioritize and monitor individuals with the greatest need;
- ◆ Local AOT program staff and local service providers meet regularly regarding treatment of AOT recipients;
- ◆ AOT ensures greater access to services for individuals whom providers have previously been reluctant to serve;
- ◆ The AOT treatment plan serves as a comprehensive planning tool to ensure that all providers and the recipient are on the 'same page';
- ◆ Positive treatment outcomes have been noted;
- ◆ Decreases in the frequency and duration of hospitalizations, incarcerations, and alcohol and substance abuse have also been noted; and

- ◆ There is now increased collaboration between inpatient and community-based mental health providers.

How AOT Evolved Over the Past Five Years

Local directors of mental health services have reported progress in their implementation of Kendra's Law. Initially, many felt challenged to manage their obligations under the Law and were unsure how to proceed. With guidance and technical assistance from OMH, local governments have established systems to address the aspects of Kendra's Law for which they maintain primary responsibility.

Over time, many local mental health directors have implemented structural changes within their existing systems to accommodate their new role as Directors of AOT programs. These changes include the development of screening teams to evaluate and investigate referrals for AOT; the establishment of mechanisms for easy collaboration between case management and ACT services and the local AOT program's clinical personnel; and the development of service alternatives for individuals who were not appropriate candidates for AOT, but for whom it was felt that some more intensive intervention was required.

Figure 1 illustrates a hypothetical AOT case, from referral to investigation, assessment, service delivery, and monitoring.

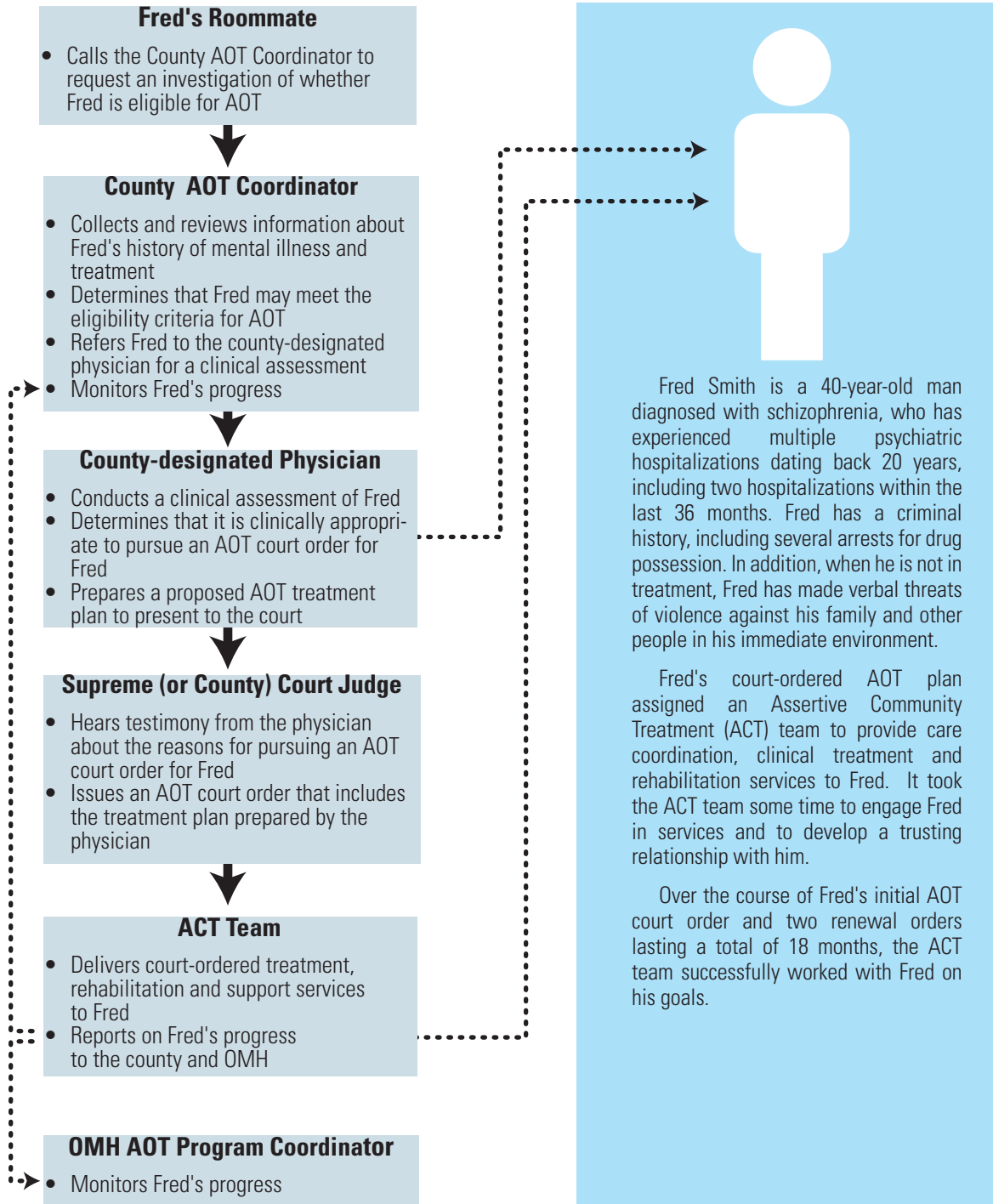
Program Evaluation Findings

In this section, we present findings from OMH's ongoing evaluation of AOT concerning: the outcomes of AOT judicial proceedings; how many individuals have received court-ordered AOT; how long individuals typically remain under court-ordered treatment; the characteristics of AOT recipients; out-

Figure 1

Fred Smith's Experience with AOT

(To prevent recognition, 'Fred Smith' is a composite of several actual AOT cases with similar histories and outcomes)



comes for AOT recipients; and the opinions of AOT recipients about court-ordered treatment and its impact. These findings derive from several sources:

- ◆ OMH Central and Field Office staff record basic information on each court order and the status of each order in an electronic tracking system. This system is used to generate regular aggregate reports on the volume of court orders throughout the state and the number of individuals receiving AOT.
- ◆ OMH collects additional information concerning AOT recipients from their case managers via a paper-based survey data collection process. Case managers complete a standardized assessment for each AOT recipient at the onset of the court order (baseline), at the end of the initial court order (six month follow-up), and, if the court order is renewed, every six months for the duration of the order. The assessments capture: demographic characteristics of AOT recipients; their status in areas such as living situation, services received, engagement in services, and adherence to prescribed medication; incidence of significant events such as hospitalization, homelessness, arrest, and incarceration; functional impairment in the areas of self-care, social skills, and task performance; and any incidence of harmful behaviors. These assessments are sent to OMH and the results entered into an evaluation database. OMH uses the resulting data to assess outcomes for all AOT recipients as a group. Due to time lags inherent in paper-based survey data collection and processing, and the limited scope of the data collected on the standardized assessments, OMH does not use the evaluation database to monitor the clinical status of individual recipients.
- ◆ A third source of information for evaluating AOT are data gathered directly from a sam-

ple of AOT recipients in New York City via face-to-face interviews conducted by researchers from the New York State Psychiatric Institute/Columbia University who are working in conjunction with OMH Central Office staff.

Summary of AOT Proceedings

Referrals/Investigations, Petitions, Court Orders and Service Enhancements:

Between November 1999 and December 31, 2004, 10,078 individuals were referred to local AOT coordinators for investigation to determine potential eligibility for an AOT court order. Referrals resulted in petitions filed for the issuance of an AOT court order for 4,041 individuals (40% of all individuals referred); of these, petitions were granted and court orders issued for 3,766 individuals (93% of all individuals with petitions filed). Investigations led to service enhancements rather than court orders for 2,863 individuals (28% of all investigations). Court orders and service enhancements have been issued in all regions of New York State, with 58% of all court orders and service enhancements occurring in New York City. Table 1 summarizes data on outcomes of the judicial procedures associated with AOT.

Table 1

Summary of AOT Judicial Proceedings Through December 31, 2004

Referrals/Investigations.....	10,078 individuals
Petitions Filed	4,041 individuals
Petitions Granted.....	3,766 individuals
Percent of Individuals for whom Petitions were Filed and Granted	93%

Table 2

AOT Court Order Renewal Rates Through December 31, 2004

Court Orders Eligible for Renewal	3,493 individuals*
Court Orders Renewed.....	2,236 individuals
% with Court Orders Renewed	64%

* This number excludes all initial court orders that, as of December 31, 2004, were still in effect (and thus not yet eligible for renewal).

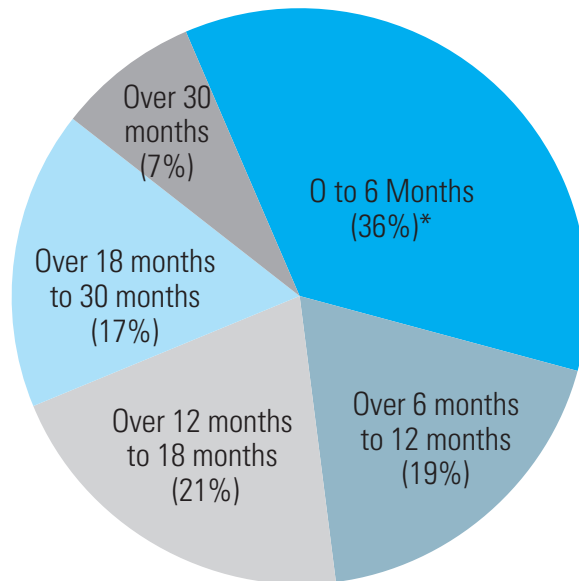
Length of Time in AOT: As noted in Table 1, as of December 31, 2004, 3,766 individuals had received court ordered treatment through AOT. Initial court orders for AOT recipients are generally six months in duration. Court orders, however, can be renewed and recipients may receive additional court orders after previous orders expire. About one third of AOT recipients spend six months under court order. Court orders for most AOT recipients (64%) are renewed and so the majority of individuals remain under court order for more than six months (Table 2). Figure 2 shows the total amount of time spent by recipients in AOT. The average length of time recipients remain under court order is 16 months.

Reasons for Non-Renewal of Court Orders:

OMH staff also collects information on the reasons for non-renewal of court-orders. The most frequently cited reason is that the individual has improved and is no longer in need of court-ordered services (76%). The next most frequently cited reason is that the individual is hospitalized at the end of the court order and a long stay in the hospital is anticipated (10%).

Figure 2

Time Recipients Spend in AOT November 1999 - December 2004



* Persons for whom an initial court order was not renewed.

Living Situation at Termination of AOT:

At the time of court order expiration most individuals were living either in independent or supervised community-based settings. Fifty two percent were living in independent settings, alone or with parents, spouses, other relatives, or other persons. Twenty-two percent were living in either assisted/supported living or supervised living settings. Twelve percent were in psychiatric inpatient settings, while three percent were incarcerated at the time their court order expired.

Characteristics of AOT Recipients

The data presented below on the characteristics of AOT recipients are for 2,745 individuals for whom data were available in the OMH evalua-

tion database at the time of this report's preparation. (The time frames associated with paper-based data collection are such that the number of individuals represented in the evaluation database is less than the total number of individuals who have received AOT.)

Demographics. Table 3 displays data on the age, sex, race/ethnicity, marital status and living situation of AOT recipients.

On average, persons in AOT are 37½ years of age and two-thirds (66%) are male. Most are unmarried and are living in independent settings in the community. The racial and ethnic composition of the population receiving court-ordered treatment is diverse: 42% of AOT recipients are Black, 34% are White and 21% are Hispanic.

Diagnoses. Most individuals (71%) receiving an AOT court order have a diagnosis of schizophrenia. Thirteen percent have a bipolar disorder diagnosis. More than half (52%) of AOT individuals are reported as having a co-occurring mental illness and substance abuse condition with mental illness as a primary diagnosis.

Incidence of Hospitalization, Homelessness, Arrest and Incarceration. Table 4 summarizes the incidence of hospitalizations, homelessness, arrest and incarceration for persons in AOT prior to court-ordered treatment. In the three years prior to the court order, 97% of individuals had at least one psychiatric hospitalization. On average, these individuals had been hospitalized approximately three times during that period with some individuals having had as many as 13 hospitalizations. Nineteen percent of individuals had experienced at least one episode of homelessness in the three years preceding their court order. Thirty percent were arrested at least one time in the three years prior to AOT. These indi-

Table 3

Characteristics of AOT Recipients

All AOT Recipients

Age	
Mean Number of Years	37.5 Years
Gender	
Male.....	66%
Female	34%
Race/Ethnicity*	
Black (non-Hispanic)	42%
White (non-Hispanic)	34%
Hispanic.....	21%
Asian	2%
Other	1%
Marital Status	
Single, never married	75%
Divorced/Widowed.....	17%
Married/Cohabiting w/significant other or domestic partner.....	8%
Current Living Situation	
Living alone	13%
Living with others	38%
Supervised Living.....	37%
Other	12%
Diagnosis of Schizophrenia or Psychotic Disorder	
71%	
Coexisting Alcohol and/or Substance Abuse Disorder	
52%	

* These proportions are similar to those observed for all adults receiving intensive case management and Assertive Community Treatment in urban areas.

Table 4

Incidence of Hospitalization, Homelessness, Arrest and Incarceration Three Years Prior to Issuance of Court-Order

Psychiatric Hospitalizations

Mean number in last 36 months	3.08
Percent hospitalized (at least one episode)	97%
Number of admissions (range)	0-13

Homeless Episodes

Mean number in last 36 months	0.27
Percent homeless (at least one episode)	19%
Number of episodes (range)	0-6

Arrests

Mean number in last 36 months	0.52
Percent arrested (at least one episode)	30%
Number of arrests (range)	0-10

Incarcerations

Mean number in last 36 months	0.35
Percent incarcerated (at least one episode)	23%
Number of incarcerations (range)	0-10

viduals had as many as ten arrests during that time. Twenty-three percent were incarcerated at least once in the three years prior to their court order. Some individuals had as many as ten incarcerations in those three years.

When compared with a similar population of mental health service recipients,³ AOT recipients were twice as likely to have had a previous episode of homelessness and 50% more likely to have had contact with the criminal justice system prior to their court order. In addition, AOT recipients were 58% more likely to have a co-occurring substance abuse problem.

Outcomes for Recipients during the First Six Months of AOT

Initial court orders for AOT recipients are usually six months long. The six month milestone is critical because it is at this juncture that decisions are made regarding renewal of the court order. Outcome findings presented in the next section focus on change between the onset of the court order and the status of recipients after six months. The results presented below are for AOT recipients for whom both baseline (onset of court order) and six-month follow-up assessments were available in the OMH evaluation database at the time of this report's preparation.

AOT was designed to ensure supervision and treatment for individuals who, without such supervision and treatment, would likely be unable to take responsibility for their own care and would be unable to live successfully in the community. For persons in AOT, the goals are to increase access to the highest intensity services and to better engage them in those services. An additional goal is to reduce the incidence of behaviors harmful to themselves or others. Participation in AOT

Notes

³ OMH derives its estimates of the number of people served annually by the public mental health system from its Patient Characteristics Survey (PCS). The PCS, which is administered every other year, gathers information about the demographic and clinical characteristics of persons receiving mental health services in programs operated, funded, or certified by OMH during a one-week period. The data presented in this section are derived from the 2003 PCS, which is the most recent available.

should result in improved adherence to prescribed medication and decreased hospitalization, homelessness, arrests, and incarceration. In addition, AOT recipients should benefit through improved functioning in important community and personal activities.

Increased Participation in Case Management and Other Services

Table 5 compares participation in services by AOT recipients prior to and subsequent to the initial court order. For all categories of service, a greater percentage of individuals are participating in the service while under court order than were receiving it prior to the court order. A dramatic example is in the area of case management. As prescribed by the legislation, all individuals receiving a court order are enrolled in case management. However, prior to AOT, only 53% of these

individuals were receiving this service.

In addition, the percentage of AOT recipients who are receiving substance abuse services increased by 67% as a result of their court-ordered treatment plan, increasing from 24% to 40%. Similarly, the percentage of persons in AOT who receive housing services as a result of their court-ordered treatment plan also increased from 19% to 31%. Substantial increases are also seen for urine or blood testing used to assess adherence to medication or substance abuse.

Increased Engagement in Services and Adherence to Prescribed Medication

Two important goals of AOT are increased engagement, i.e., active and regular participation in services; and increased adherence to prescribed medication, i.e., taking medications

Table 5

Services Received by AOT Recipients Participation Rates Prior to AOT and During AOT

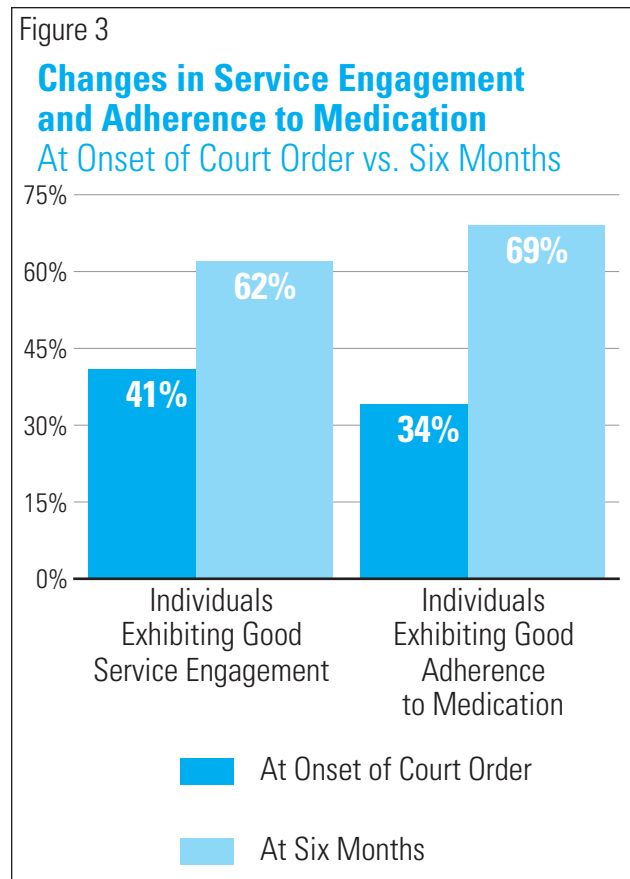
Service	Percentage of AOT Recipients		Percent Increase
	Prior to AOT	At Six Months	
Case Management	53%	100%	89%
Medication Management	60%	88%	47%
Individual or Group Therapy	51%	75%	47%
Day Programs	15%	22%	47%
Substance Abuse Services	24%	40%	67%
Housing or Housing Support Services	19%	31%	63%
Urine or Blood Toxicology (adherence to medication)	18%	37%	106%
Urine or Blood Toxicology (substance abuse)	17%	35%	106%

necessary to manage psychiatric symptoms as directed by the treating physician. To assess engagement, case managers were asked to rate the engagement of persons in AOT using a scale ranging from “not at all engaged in services” to “independently and appropriately uses services.” Recipients were considered to have “good engagement” if they received a rating of either “good – able to partner and can use resources independently” or “excellent – independently and appropriately uses services.” Data collected since the onset of AOT show the percent of individuals who exhibit good engagement in services increased significantly from 41% to 62% at six months.

To assess medication adherence, case managers were asked to rate adherence of persons in AOT using a scale ranging from “taking medication exactly as prescribed” to “rarely or never taking medication as prescribed.” Recipients were considered to have “good adherence to medication” if they were rated as either “takes medication as prescribed most of the time” or “takes medication as prescribed.” The resulting data show that the percent of individuals with good medication adherence increased significantly from 34% to 69% after six months. Figure 3 displays the improvement in engagement in services and adherence to medications after six months of AOT participation.

Improved Community and Social Functioning

The evaluation database also documents changes in AOT recipients' day-to-day functioning. Measures that are used for this assessment are the Global Assessment of Functioning (GAF) and three sets of items that assess individuals' abilities in specific functional areas: self-care, social and community living



skills, and task performance. The GAF is a commonly used measure of overall functioning. It includes social, occupational, academic, and other areas of personal performance and results in an overall numerical rating score which can range from 0 to 100. A score of 50 or below denotes serious impairment in social, occupational or school functioning. At the onset of an AOT court order, 39% of individuals had a GAF score below 50. After receiving services under an AOT court order for six months, the percentage of persons with a GAF score below 50 dropped to 33%.

AOT recipients' functioning in the area of self-care and community living also improved after six months of program participation. Table 6 displays the change in these measures. The table compares the percentage of

Table 6

Improvements in Self Care and Community Living

	Percent of AOT Recipients with Difficulties		Percent Reduction in Difficulties
	At Onset of AOT Court Order	At Six Months	
Access community services	23%	16%	30%
Prepare meals	17%	12%	29%
Take care of own possessions	14%	10%	29%
Maintain adequate personal hygiene	7%	5%	29%
Follow through on health care advice	26%	19%	27%
Make and keep appointments	27%	20%	26%
Manage medication	36%	27%	25%
Take care of own living space	16%	12%	25%
Maintain adequate diet	9%	7%	22%
Handle finances	29%	25%	14%
Avoid dangers	7%	6%	14%
Shop for food, etc.	16%	14%	13%
Access transportation	9%	8%	11%
Average Percent Reduction			23%

persons in AOT who were reported as having difficulty at the onset of their court ordered treatment with the percentage reported as having difficulty six months later. For all items, there were fewer individuals rated as having difficulty, and in all measures the change was statistically significant. Although changes are relatively small in magnitude for any single measure, a consistent pattern of overall improvement (reduction in difficulties) is seen across all areas of self-care and community functioning.

Among the items included on Table 6, some measures can be linked to the AOT program's goals of increasing adherence to medication and increasing engagement in services. In particular, the percent of AOT recipients who had difficulty managing medication decreased from 36% to 27% between the onset of the court order and six months. Similarly, the percent of recipients who had difficulty following through on health care advice and making and keeping appointments declined from 26% to 19% and 27% to 20% respectively.

Table 7

Improvements in Social, Interpersonal, and Family Functioning

	Percent of AOT Recipients with Difficulties		Percent Reduction in Difficulties
	At Onset of AOT Court Order	At Six Months	
Ask for help when needed	28%	20%	29%
Effectively handle conflict	50%	36%	28%
Manage assertiveness	44%	33%	25%
Engage in social/family activities	34%	26%	24%
Communicate clearly	13%	10%	23%
Respond to social contact	20%	16%	20%
Maintain support network	40%	33%	18%
Manage leisure time	28%	24%	14%
Average Percent Reduction			22%

Tables 7 and 8 display the changes during the initial six months of AOT in the areas of social, interpersonal and family functioning and task performance. On 15 of the 16 measures for these areas, the reduction in difficulties experienced by AOT recipients between the onset of the court order and at six months was statistically significant. For instance, the percent of recipients who had difficulty effectively handling conflict and managing assertiveness dropped from 50% to 36% and 44% to 33% respectively. Similar to the findings noted above for self care and community living, an overall pattern of reduced difficulties and therefore improved functioning characterizes the findings concerning social, interpersonal and family functioning, and task performance.

Table 8

Improvements in Task Performance

	Percent of AOT Recipients with Difficulties		Percent Reduction in Difficulties
	At Onset of AOT Court Order	At Six Months	
Understand and remember instructions	19%	14%	26%
Perform in coordination with or in proximity to others without being distracted by them	28%	21%	25%
Sustain an ordinary routine without special supervision	33%	25%	24%
Perform activities within a schedule, maintain regular attendance and be on time	33%	25%	24%
Maintain attention and concentration spans	25%	19%	24%
Complete tasks without assistance	28%	22%	21%
Perform at a consistent pace without unreasonable rest periods	27%	22%	19%
Complete tasks without errors	27%	22%	19%
Average Percent Reduction			23%

Table 9

Reduced Incidence of Harmful Behaviors (Percent of Persons with One or More Events Reported in the Past 90 Days)

	Percent of AOT Recipients with Harmful Behaviors		Percent Reduction in Harmful Behaviors
	At Onset of AOT Court Order	At Six Months	
Physically Harm Self/Made Suicide Attempt	9%	4%	55%
Abuse Alcohol	45%	23%	49%
Abuse Drugs	44%	23%	48%
Threaten Suicide	15%	8%	47%
Physically Harm Others	15%	8%	47%
Damage or Destroy Property	13%	7%	46%
Threaten Physical Harm	28%	16%	43%
Create Public Disturbances	24%	15%	38%
Verbally Assault Others	33%	21%	36%
Theft	7%	5%	29%
Average Percent Reduction			44%

Reduced Incidence of Harmful Behaviors

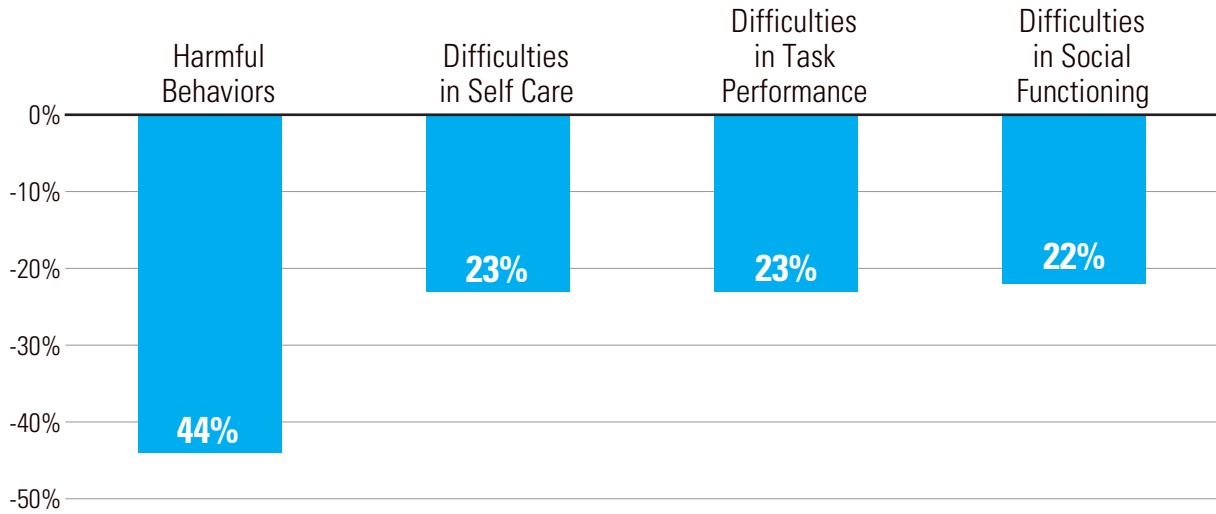
Case managers also reported reductions in the incidence of harmful behaviors for AOT recipients at six months in AOT when compared with a comparable period of time prior to AOT. Table 9 shows significant declines in the incidence of behaviors harmful to self, behaviors harmful to others, and harmful behaviors directed at property. Similarly, substantial declines are also seen in alcohol and substance abuse.

In summary, during the first six months of court-ordered treatment, individuals in AOT showed a significant decline in the incidence of harmful behaviors.

The average percent decrease in harmful behaviors was 44%. In addition, over the same amount of time AOT recipients showed significant improvement in the areas of self care and community living, task performance, and social, family and interpersonal functioning. The average percent decrease in difficulties for all measures in these areas between the onset of the court order and six months was 23%, 23% and 22% respectively. These improvements are summarized in Figure 4.

Figure 4

Average Percent Reduction in Harmful Behaviors and Difficulties Across All Categories of Functioning



Longer Term Findings: Outcomes for AOT Recipients Beyond the Initial Six Months

As noted earlier, the majority of recipients remain in AOT longer than the initial court order period of six months, with the average total length of time in AOT being 16 months. To assess outcomes for these individuals over their entire course of AOT, OMH continues to collect evaluation data at six month intervals until AOT program termination. This section discusses AOT recipient outcomes achieved over the entire course of court-ordered treatment.

Reduced Incidence of Hospitalization, Homelessness, Arrest and Incarceration

During the entire time of participation in AOT, large decreases in the incidence of hospitalization, homelessness, arrest and incarceration are seen for recipients when compared to pre-

AOT levels. Table 10 and Figure 5 summarize change in the occurrence of these events. Three years prior to AOT, 23% of AOT recipients had at least one incarceration. While in AOT, only 3% of recipients experienced an incarceration, a decrease of 87%. Over the same time comparison, the incidence of arrest, psychiatric hospitalization, and homelessness declined 83%, 77%, and 74%, respectively.

Reductions in Days Hospitalized for Psychiatric Care

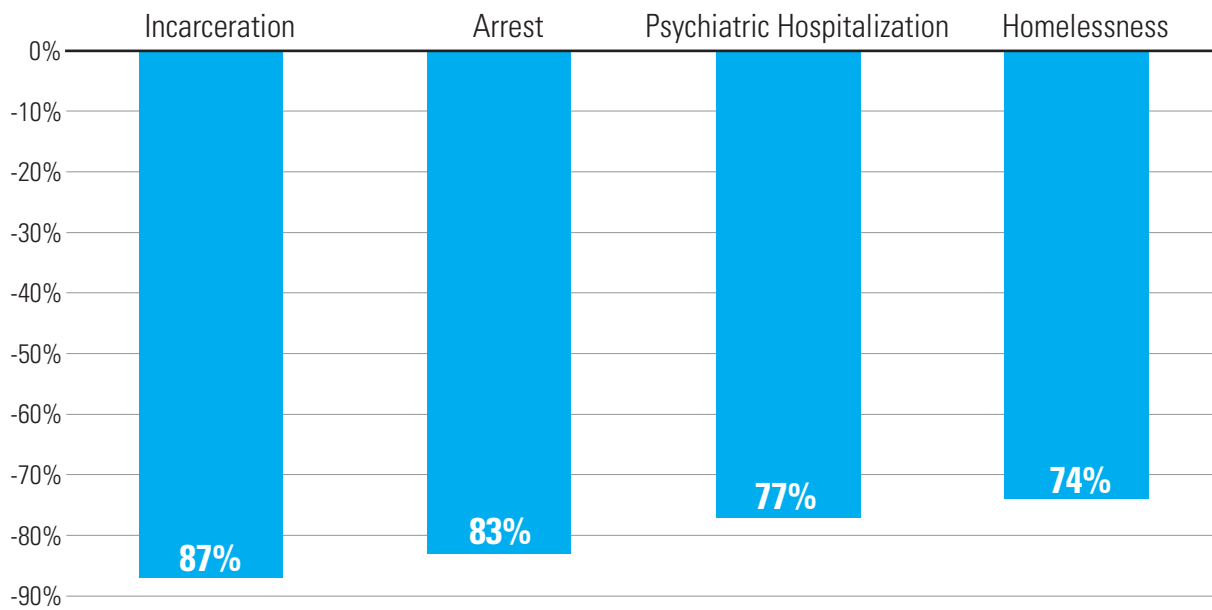
OMH evaluation staff examined changes in the total number of days individuals spent hospitalized before, during and after AOT. On average, AOT recipients spent 50 days hospitalized for psychiatric care during the six months prior to court-ordered treatment. While receiving court-ordered treatment, recipients' days hospitalized dropped to an average of 22 days per six month period, a reduction of 56%. Days hospitalized continued

Table 10

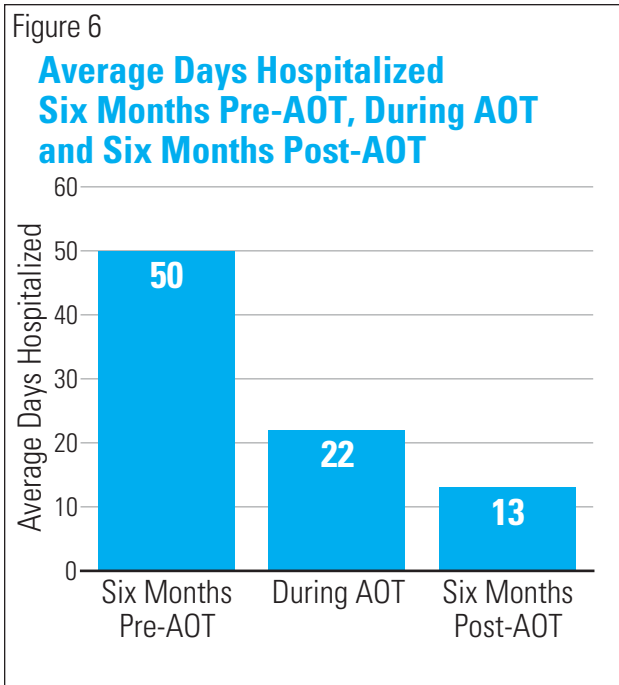
Reduced Incidence of Significant Events for AOT Recipients

	Prior to AOT	During AOT	Percent Reduction
Incarceration	23%	3%	87%
Arrest	30%	5%	83%
Psychiatric Hospitalization	97%	22%	77%
Homelessness	19%	5%	74%

Figure 5

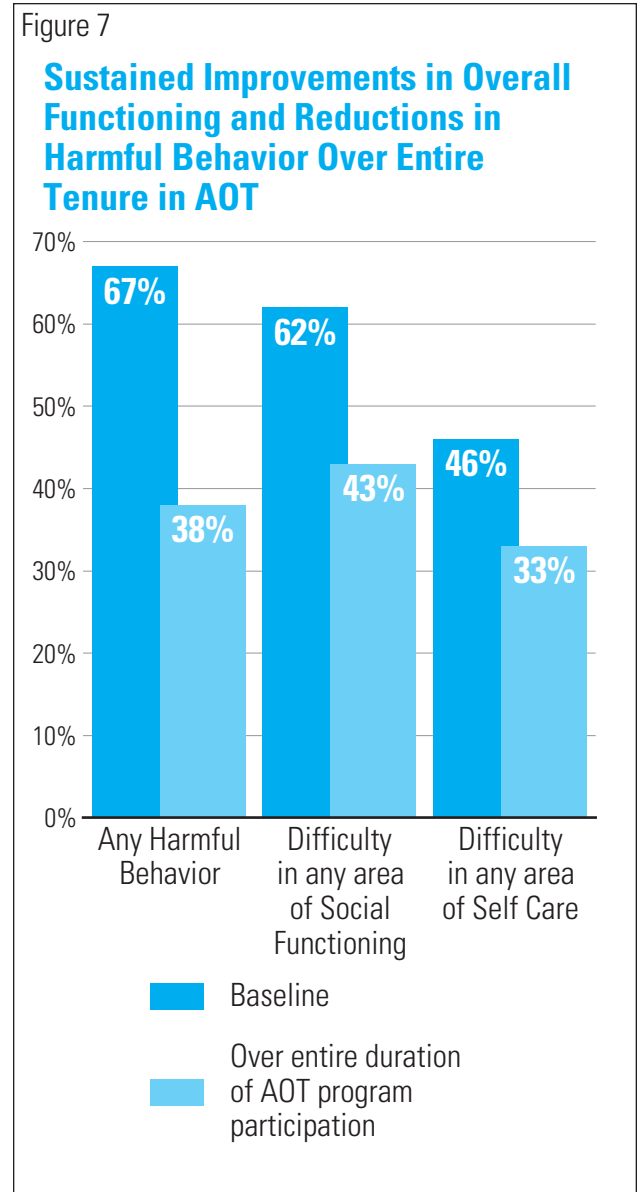
Reduced Incidence of Significant Events for AOT Recipients

to decline even after the end of court-ordered treatment: during the first six months after termination of the court order, total days hospitalized dropped to an average of 13 days, a reduction of 74% from the pre-AOT total (Figure 6).



Sustained Improvements in Overall Functioning and Reductions in Harmful Behaviors

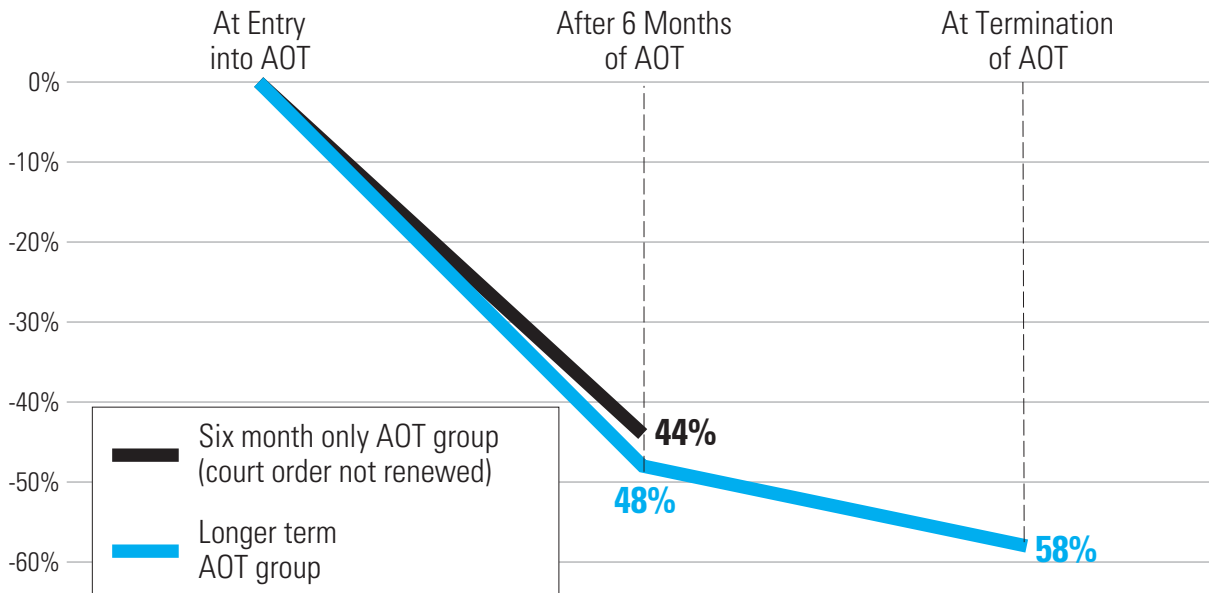
On average, AOT recipients continued to experience gains in social and community functioning and reductions in harmful behaviors throughout the duration of court-ordered treatment (Figure 7). Gains made during the initial six months of AOT were retained over time, and on some measures additional improvement occurred after the first six months. For instance, by the end of court-ordered treatment, 27% of AOT recipients achieved a substantial improvement in overall functioning (defined as a 10 point or greater gain on the GAF). Figure 8 below compares the percent reduction in harmful behaviors for recipients who leave AOT after six months versus recipients who remain in AOT longer than six months. As the chart shows, both groups experience a nearly identical reduction during the initial six month period following the court-order. The group remaining in AOT



experiences further reductions in harmful behavior during their remaining time under court-order; however, these changes are smaller in magnitude than the declines experienced during the initial six month period.

Figure 8

Percent Reduction in Harmful Behaviors Over Entire Course of AOT



Opinions of AOT Recipients Concerning Court-ordered Treatment

This final set of findings are preliminary results from face-to-face interviews of AOT recipients conducted by researchers at New York State Psychiatric Institute (NYSPI)/Columbia University as part of an ongoing study comparing community outcomes for AOT recipients to those experienced by a comparison group of non-AOT outpatient service recipients. The NYSPI/Columbia study is focused on a sample of AOT recipients (n=76 to date) receiving court-ordered treatment in New York City (Bronx and Queens). Through face-to-face interviews, researchers assess recipients' recent service histories, opinions about AOT, strength of the working alliance between recipient and AOT case manager, and other

factors relevant to AOT including perceived coercion and stigma, perceived efficacy of services received through AOT, and quality of life. Interviews are being repeated at three, six, nine and 12 month intervals to assess changes over time. (OMH anticipates that final results from this study will be available in 2006.)

Concerning the experience of being court-ordered into treatment, about half of the AOT recipients interviewed reported feeling angry (54%) or embarrassed (53%) by the experience. However, 62% of AOT recipients also reported that, all things considered, being court-ordered into treatment has been a good thing for them. Concerning the emphasis in AOT on the importance of remaining engaged in needed services over time, the majority of AOT recipients interviewed reported that the pressures or things people

have done to get them to stay in treatment helped them to get and stay well (81%), gain control over their lives (75%), and made them more likely to keep appointments and take medication (90%). Concerning the working alliance between AOT recipients and their case managers, the majority reported that they were confident in their case manager's ability to help them (87%) and that they and their case managers agree on what is important for them to work on (88%).

Summary

The Preamble to Kendra's Law states that the intent of the act is to "amend the mental hygiene law in relation to enhancing the supervision and coordination of care of persons with mental illness in community-based settings by providing assisted outpatient treatment." This Final Report illustrates the degree to which the State of New York has successfully fulfilled the intent of the legislation. Since Kendra's Law was enacted in August 1999, the State has responded in ways which suggest that the intent of the legislation is being realized. Since 1999, 10,078 individuals have been referred for a potential court order. As of December 31, 2004, 3,766 individuals have received services under an AOT order and an additional 2,863 have received service enhancements as a result of referral for a potential court order.

The local monitoring and oversight systems which are responsible for the administration of the AOT program operate under standards and guidelines set forth by OMH. Development and refinement of these standards and guidelines are part of the State's commitment to continual review of program performance and quality improvement. Areas which have been the subject of standardized State policies include the dissemination of

clinical risk information, specific policies on the coordination of care, review of residential placements for AOT recipients, and uniform procedures for the reporting of unexplained program and residential absences. Because State and local governments continually monitor the AOT program, management strategies to promote quality are ongoing.

Programmatic improvements are, however, only part of this AOT Final Report. It is the people who have used the program successfully who matter most when summarizing the results of this legislation. People in AOT have been able to improve their involvement in the service system as a result of their participation in the program, and by doing so, they have improved their lives. There has been an 89% increase in use of case management services among AOT recipients, and substantial increases in utilizing both substance abuse and housing support services. There have also been significant improvements reported in self care and community functioning and a 44% decline in the incidence of harmful behaviors (e.g., suicide threats, self harm, and harm to others).

For the people who have benefited from participation in services mandated under an AOT order, these positive outcomes are more than statistics; they are tangible evidence that the system of care has been responsive to their needs. These are individuals who, without Kendra's Law, had limited experience of success in using mental health services. Over a three year period prior to their AOT order, almost all (97%) had been hospitalized (with an average of three hospitalizations per recipient), and many experienced homelessness, arrest, and incarceration. During participation in the AOT program, rates for hospitalizations, homelessness, arrests, and incarceration

tions have declined significantly, and program participants have experienced a lessening of the stress associated with these events.

This Final Report on the AOT Program demonstrates that program participants are able to make gains in their recovery process and maintain them over the duration of their AOT participation and beyond. All AOT

recipients receive benefits from case management or ACT services, and from the local systems of monitoring and oversight which have been created in response to the legislation. OMH recommends that Kendra's Law be extended permanently so these benefits can continue to be provided to those New Yorkers who require the support afforded to them through an AOT order.

Appendix 1

Laws of New York, 1999

Chapter 408

AN ACT to amend the mental hygiene law, in relation to enhancing the supervision and coordination of care of persons with mental illness in community-based settings by providing assisted outpatient treatment and to amend chapter 560 of the laws of 1994 amending the judiciary law and the mental hygiene law relating to establishing a pilot program of involuntary outpatient treatment, in relation to the effectiveness of such chapter and providing for the repeal of such provision on the expiration thereof

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act shall be known and may be cited as "Kendra's Law".

§ 2. Legislative findings. The legislature finds that there are mentally ill persons who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization. The legislature further finds that there are mentally ill persons who can function well and safely in the community with supervision and treatment, but who without such assistance, will relapse and require long periods of hospitalization. The legislature further finds that some mentally ill persons, because of their illness, have great difficulty taking responsibility for their own care, and often reject the outpatient treatment offered to them on a volun-

tary basis. Family members and caregivers often must stand by helplessly and watch their loved ones and patients decompensate. Effective mechanisms for accomplishing these ends include: the establishment of assisted outpatient treatment as a mode of treatment; improved coordination of care for mentally ill persons living in the community; the expansion of the use of conditional release in psychiatric hospitals; and the improved dissemination of information between and among mental health providers and general hospital emergency rooms. The legislature further finds that if such court-ordered treatment is to achieve its goals, it must be linked to a system of comprehensive care, in which state and local authorities work together to ensure that outpatients receive case management and have access to treatment services. The legislature therefore finds that assisted outpatient treatment as provided in this act is compassionate, not punitive, will restore patients' dignity, and will enable mentally ill persons to lead more productive and satisfying lives. The legislature further finds that many mentally ill persons are more likely to enjoy recovery from non-dangerous, temporary episodes of mental illness when they are engaged in planning the nature of the medications, programs or treatments for such episodes with assistance and support from family, friends and mental health professionals. A health care proxy executed pursuant to article 29-C of the public health law provides mentally ill persons with a means to accept individual

Explanation: Matter that is underscored (example) is new; matter in brackets and struck through (example) is old law to be omitted

responsibility for their own continuing mental health care by providing advance directives concerning their wishes as to medications, programs or treatments that they feel are appropriate when they are temporarily unable to make mental health care decisions. The legislature therefore finds that the voluntary use of such proxies should be encouraged so as to minimize the need for involuntary mental health treatment.

§ § 3. Section 7.17 of the mental hygiene law is amended by adding a new subdivision (f) to read as follows:

(f) (1) The commissioner shall appoint program coordinators of assisted outpatient treatment, who shall be responsible for the oversight and monitoring of assisted outpatient treatment programs established pursuant to section 9.60 of this chapter. Directors of community services of local governmental units shall work in conjunction with such program coordinators to coordinate the implementation of assisted outpatient treatment programs.

(2) The oversight and monitoring role of the program coordinator of the assisted outpatient treatment program shall include each of the following:

(i) that each assisted outpatient receives the treatment provided for in the court order issued pursuant to section 9.60 of this chapter;

(ii) that existing services located in the assisted outpatient's community are utilized whenever practicable;

(iii) that a case manager or assertive community treatment team is designated for each assisted outpatient;

(iv) that a mechanism exists for such case manager, or assertive community treatment team, to regularly report the assisted outpatient's compliance, or lack of compliance with treatment, to the director of the assisted outpatient treatment program; and

(v) that assisted outpatient treatment services are delivered in a timely manner.

(3) The commissioner shall develop standards designed to ensure that case managers or assertive community treatment teams have appropriate training and have clinically manageable caseloads designed to provide effective case management or other care coordination services for persons subject to a court order under section 9.60 of this chapter.

(4) Upon review or receiving notice that services are not being delivered in a timely manner, the program coordinator shall require the director of such assisted outpatient treatment program to immediately commence corrective action and inform the program coordinator of such corrective action. Failure of a director to take corrective action shall be reported by the program coordinator to the commissioner of mental health, as well as to the court which ordered the assisted outpatient treatment.

4. The opening paragraph of section 9.47 of the mental hygiene law is designated subdivision (a) and a new subdivision (b) is added to read as follows:

(b) All directors of community services shall be responsible for the filing of petitions for assisted outpatient treatment pursuant to paragraph (vi) of subdivision (e) of section 9.60 of this article, for the receipt and investigation of reports of persons who are alleged to be in need of such treatment and for coordinating the delivery of court ordered services with program coordinators, appointed by the commissioner of mental health, pursuant to subdivision (f) of section 7.17 of this chapter. In discharge of the duties imposed by subdivision (b) of section 9.60 of this article, directors of community services may provide services directly, or may coordinate services with the offices of the department or may contract with any public or private provider to provide services for such programs as may be necessary to carry out the duties imposed pursuant to this subdivision.

§ § 5. The mental hygiene law is amended by adding a new section 9.48 to read as follows:

§ § 9.48 Duties of directors of assisted outpatient treatment programs.

(a)(1) Directors of assisted outpatient treatment programs established pursuant to section 9.60 of this article shall provide a written report to the program coordinators, appointed by the commissioner of mental health pursuant to subdivision (f) of section 7.17 of this chapter, within three days of the issuance of a court order. The report shall demonstrate that mechanisms are in place to ensure the delivery of services and medications as required by the court order and shall include, but not be limited to the following:

- (i) a copy of the court order;
- (ii) a copy of the written treatment plan;
- (iii) the identity of the case manager or assertive community treatment team, including the name and contact data of the organization which the case manager or assertive community treatment team member represents;
- (iv) the identity of providers of services; and
- (v) the date on which services have commenced or will commence.

(2) The directors of assisted outpatient treatment programs shall ensure the timely delivery of services described in paragraph one of subdivision (a) of section 9.60 of this article pursuant to any court order issued under such section. Directors of assisted outpatient treatment programs shall immediately commence corrective action upon receiving notice from program coordinators, that services are not being provided in a timely manner. Such directors shall inform the program coordinator of such corrective action.

(b) Directors of assisted outpatient treatment programs shall submit quarterly reports to the program coordinators regarding the assisted outpatient treatment program operated or administered by such director. The report shall include the following information:

- (i) the names of individuals served by the program;
- (ii) the percentage of petitions for assisted outpatient treatment that are granted by the court;
- (iii) any change in status of assisted outpatients, including but not limited to the number of individuals who have failed to comply with court ordered assisted outpatient treatment;

(iv) a description of material changes in written treatment plans of assisted outpatients;

(v) any change in case managers;

(vi) a description of the categories of services which have been ordered by the court;

(vii) living arrangements of individuals served by the program including the number, if any, who are homeless;

(viii) any other information as required by the commissioner of mental health; and

(ix) any recommendations to improve the program locally or statewide.

§ § 6. The mental hygiene law is amended by adding a new section 9.60 to read as follows:

9.60 Assisted outpatient treatment.

(a) Definitions. For purposes of this section, the following definitions shall apply:

(1) "assisted outpatient treatment" shall mean categories of outpatient services which have been ordered by the court pursuant to this section. Such treatment shall include case management services or assertive community treatment team services to provide care coordination, and may also include any of the following categories of services: medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; educational and vocational training or activities; alcohol or substance abuse treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for persons with a history of alcohol or substance abuse; supervision of living arrangements; and any other services within a local or unified services plan developed pursuant to article forty-one of this chapter, prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

(2) "director" shall mean the director of a hospital licensed or operated by the office of mental health which operates, directs and supervises an assisted outpatient treatment program, or the director of community services of a local governmental unit, as such term is defined in section 41.03 of this chapter,

which operates, directs and supervises an assisted outpatient treatment program.

(3) "director of community services" shall have the same meaning as provided in article forty-one of this chapter.

(4) "assisted outpatient treatment program" shall mean a system to arrange for and coordinate the provision of assisted outpatient treatment, to monitor treatment compliance by assisted outpatients, to evaluate the condition or needs of assisted outpatients, to take appropriate steps to address the needs of such individuals, and to ensure compliance with court orders.

(5) "assisted outpatient" or "patient" shall mean the person under a court order to receive assisted outpatient treatment.

(6) "subject of the petition" or "subject" shall mean the person who is alleged in a petition, filed pursuant to the provisions of this section, to meet the criteria for assisted outpatient treatment.

(7) "correctional facility" or "local correctional facility" shall have the same meaning as defined in section two of the correction law.

(8) "health care proxy" and "health care agent" shall have the same meaning as defined in article 29-C of the public health law.

(9) "program coordinator" shall mean an individual appointed by the commissioner of mental health, pursuant to subdivision (f) of section 7.17 of this chapter, who is responsible for the oversight and monitoring of assisted outpatient treatment programs.

(b) The director of a hospital licensed or operated by the office of mental health may operate, direct and supervise an assisted outpatient treatment program as provided in this section, upon approval by the commissioner of mental health. The director of community services of a local governmental unit shall operate, direct and supervise an assisted outpatient treatment program as provided in this section, upon approval by the commissioner of mental health. Directors of community services of local governmental units shall be permitted to satisfy the provisions of this subdivision through the operation of joint assisted outpatient treatment programs. Nothing in this subdivision shall be interpreted to pre-

clude the combination or coordination of efforts between and among local governmental units and hospitals in providing and coordinating assisted outpatient treatment.

(c) Criteria for assisted outpatient treatment. A patient may be ordered to obtain assisted outpatient treatment if the court finds that:

(1) the patient is eighteen years of age or older; and

(2) the patient is suffering from a mental illness; and

(3) the patient is unlikely to survive safely in the community without supervision, based on a clinical determination; and

(4) the patient has a history of lack of compliance with treatment for mental illness that has:

(i) 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 mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition or;

(ii) 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 period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition; and

(5) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and

(6) in view of the patient's treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others as defined in section 9.01 of this article; and

(7) it is likely that the patient will benefit from assisted outpatient treatment; and

(8) if the patient has executed a health care proxy as defined in article 29-C of the public health law, that any directions included

in such proxy shall be taken into account by the court in determining the written treatment plan.

(d) Nothing herein shall preclude a person with a health care proxy from being subject to a petition pursuant to this chapter and consistent with article 29-C of the public health law.

(e) Petition to the court. (1) A petition for an order authorizing assisted outpatient treatment may be filed in the supreme or county court in the county in which the subject of the petition is present or reasonably believed to be present. A petition to obtain an order authorizing assisted outpatient treatment may be initiated only by the following persons:

(i) any person eighteen years of age or older with whom the subject of the petition resides; or

(ii) the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or

(iii) the director of a hospital in which the subject of the petition is hospitalized; or

(iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; or

(v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or

(vi) the director of community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or

(vii) a parole officer or probation officer assigned to supervise the subject of the petition.

(2) The petition shall state:

(i) each of the criteria for assisted outpatient treatment as set forth in subdivision (c) of this section;

(ii) facts which support such petitioner's belief that the person who is the subject of the petition meets each criterion, provided that the hearing on the petition need not be limited to the stated facts; and

(iii) that the subject of the petition is present, or is reasonably believed to be present, within the county where such petition is filed.

(3) The petition shall be accompanied by an affirmation or affidavit of a physician, who shall not be the petitioner, and shall state either that:

(i) such physician has personally examined the person who is the subject of the petition no more than ten days prior to the submission of the petition, he or she recommends assisted outpatient treatment for the subject of the petition, and he or she is willing and able to testify at the hearing on the petition; or

(ii) no more than ten days prior to the filing of the petition, such physician or his or her designee has made appropriate attempts to elicit the cooperation of the subject of the petition but has not been successful in persuading the subject to submit to an examination, that such physician has reason to suspect that the subject of the petition meets the criteria for assisted outpatient treatment, and that such physician is willing and able to examine the subject of the petition and testify at the hearing on the petition.

(f) Service. The petitioner shall cause written notice of the petition to be given to the subject of the petition and a copy thereof shall be given personally or by mail to the persons listed in section 9.29 of this article, the mental hygiene legal service, the current health care agent appointed by the subject of the petition, if any such agent is known to the petitioner, the appropriate program coordinator, the appropriate director of community services, if such director is not the petitioner.

(g) Right to counsel. The subject of the petition shall have the right to be represented by the mental hygiene legal service, or other counsel at the expense of the subject of the petition, at all stages of a proceeding commenced under this section.

(h) Hearing. (1) Upon receipt by the court of the petition submitted pursuant to subdivision (e) of this section, the court shall fix the date for a hearing at a time not later than three days from the date such petition is received by the court, excluding Saturdays, Sundays and holidays. Adjournments shall be permitted only for good cause shown. In granting

adjournments, the court shall consider the need for further examination by a physician or the potential need to provide assisted outpatient treatment expeditiously. The court shall cause the subject of the petition, any other person receiving notice pursuant to subdivision (f) of this section, the petitioner, the physician whose affirmation or affidavit accompanied the petition, the appropriate director, and such other persons as the court may determine to be advised of such date. Upon such date, or upon such other date to which the proceeding may be adjourned, the court shall hear testimony and, if it be deemed advisable and the subject of the petition is available, examine the subject alleged to be in need of assisted outpatient treatment in or out of court. If the subject of the petition does not appear at the hearing, and appropriate attempts to elicit the attendance of the subject have failed, the court may conduct the hearing in such subject's absence. If the hearing is conducted without the subject of the petition present, the court shall set forth the factual basis for conducting the hearing without the presence of the subject of the petition.

(2) The court shall not order assisted outpatient treatment unless an examining physician, who has personally examined the subject of the petition within the time period commencing ten days before the filing of the petition, testifies in person at the hearing.

(3) If the subject of the petition has refused to be examined by a physician, the court may request the subject to consent to an examination by a physician appointed by the court. If the subject of the petition does not consent and the court finds reasonable cause to believe that the allegations in the petition are true, the court may order peace officers, acting pursuant to their special duties, or police officers who are members of an authorized police department or force, or of a sheriff's department to take the subject of the petition into custody and transport him or her to a hospital for examination by a physician. Retention of the subject of the petition under such order shall not exceed twenty-four hours. The examination of the subject of the petition may be performed by the physician whose affirmation or affidavit accompanied

the petition pursuant to paragraph three of subdivision (e) of this section, if such physician is privileged by such hospital or otherwise authorized by such hospital to do so. If such examination is performed by another physician of such hospital, the examining physician shall be authorized to consult with the physician whose affirmation or affidavit accompanied the petition regarding the issues of whether the allegations in the petition are true and whether the subject meets the criteria for assisted outpatient treatment.

(4) A physician who testifies pursuant to paragraph two of this subdivision shall state the facts which support the allegation that the subject meets each of the criteria for assisted outpatient treatment, and the treatment is the least restrictive alternative, the recommended assisted outpatient treatment, and the rationale for the recommended assisted outpatient treatment. If the recommended assisted outpatient treatment includes medication, such physician's testimony shall describe the types or classes of medication which should be authorized, shall describe the beneficial and detrimental physical and mental effects of such medication, and shall recommend whether such medication should be self-administered or administered by authorized personnel.

(5) The subject of the petition shall be afforded an opportunity to present evidence, to call witnesses on behalf of the subject, and to cross-examine adverse witnesses.

(i) (1) Written treatment plan. The court shall not order assisted outpatient treatment unless an examining physician appointed by the appropriate director develops and provides to the court a proposed written treatment plan. The written treatment plan shall include case management services or assertive community treatment teams to provide care coordination. The written treatment plan also shall include all categories of services, as set forth in paragraph one of subdivision (a) of this section, which such physician recommends that the subject of the petition should receive. If the written treatment plan includes medication, it shall state whether such medication should be self-administered or administered by authorized personnel, and shall specify type and dosage range of medication most likely to pro-

vide maximum benefit for the subject. If the written treatment plan includes alcohol or substance abuse counseling and treatment, such plan may include a provision requiring relevant testing for either alcohol or illegal substances provided the physician's clinical basis for recommending such plan provides sufficient facts for the court to find (i) that such person has a history of alcohol or substance abuse that is clinically related to the mental illness; and (ii) that such testing is necessary to prevent a relapse or deterioration which would be likely to result in serious harm to the person or others. In developing such a plan, the physician shall provide the following persons with an opportunity to actively participate in the development of such plan: the subject of the petition; the treating physician; and upon the request of the patient, an individual significant to the patient including any relative, close friend or individual otherwise concerned with the welfare of the subject. If the petitioner is a director, such plan shall be provided to the court no later than the date of the hearing on the petition.

(2) The court shall not order assisted outpatient treatment unless a physician testifies to explain the written proposed treatment plan. Such testimony shall state the categories of assisted outpatient treatment recommended, the rationale for each such category, facts which establish that such treatment is the least restrictive alternative, and, if the recommended assisted outpatient treatment includes medication, the types or classes of medication recommended, the beneficial and detrimental physical and mental effects of such medication, and whether such medication should be self-administered or administered by an authorized professional. If the petitioner is a director such testimony shall be given at the hearing on the petition.

(j) Disposition. (1) If after hearing all relevant evidence, the court finds that the subject of the petition does not meet the criteria for assisted outpatient treatment, the court shall dismiss the petition.

(2) If after hearing all relevant evidence, the court finds by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment, and

there is no appropriate and feasible less restrictive alternative, the court shall be authorized to order the subject to receive assisted outpatient treatment for an initial period not to exceed six months. In fashioning the order, the court shall specifically make findings by clear and convincing evidence that the proposed treatment is the least restrictive treatment appropriate and feasible for the subject. The order shall state the categories of assisted outpatient treatment, as set forth in subdivision (a) of this section, which the subject is to receive, and the court may not order treatment that has not been recommended by the examining physician and included in the written treatment plan for assisted outpatient treatment as required by subdivision (i) of this section. (3) If after hearing all relevant evidence the court finds by clear and convincing evidence that the subject of the petition meets the criteria for assisted outpatient treatment, and the court has yet to be provided with a written proposed treatment plan and testimony pursuant to subdivision (i) of this section, the court shall order the director of community services to provide the court with such plan and testimony no later than the third day, excluding Saturdays, Sundays and holidays, immediately following the date of such order. Upon receiving such plan and testimony, the court may order assisted outpatient treatment as provided in paragraph two of this subdivision.

(4) A court may order the patient to self-administer psychotropic drugs or accept the administration of such drugs by authorized personnel as part of an assisted outpatient treatment program. Such order may specify the type and dosage range of such psychotropic drugs and such order shall be effective for the duration of such assisted outpatient treatment.

(5) If the petitioner is the director of a hospital that operates an assisted outpatient treatment program, the court order shall direct the hospital director to provide or arrange for all categories of assisted outpatient treatment for the assisted outpatient throughout the period of the order. For all other persons, the order shall require the director of community services of the appropriate local governmental unit to provide or arrange for all categories of

assisted outpatient treatment for the assisted outpatient throughout the period of the order.

(6) The director or his or her designee shall apply to the court for approval before instituting a proposed material change in the assisted outpatient treatment order unless such change is contemplated in the order. Non-material changes may be instituted by the assisted outpatient treatment program without court approval. For the purposes of this subdivision, a material change shall mean an addition or deletion of a category of assisted outpatient treatment from the order of the court, or any deviation without the patient's consent from the terms of an existing order relating to the administration of psychotropic drugs. Any such application for approval shall be served upon those persons required to be served with notice of a petition for an order authorizing assisted outpatient treatment.

(k) Applications for additional periods of treatment. If the director determines that the condition of such patient requires further assisted outpatient treatment, the director shall apply prior to the expiration of the period of assisted outpatient treatment ordered by the court for a second or subsequent order authorizing continued assisted outpatient treatment for a period not to exceed one year from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with the provisions of the foregoing subdivisions of this section, provided that the time period included in subparagraphs (i) and (ii) of paragraph four of subdivision (c) of this section shall not be applicable in determining the appropriateness of additional periods of assisted outpatient treatment. Any court order requiring periodic blood tests or urinalysis for the presence of alcohol or illegal drugs shall be subject to review after six months by the physician who developed the written treatment plan or another physician designated by the director, and such physician shall be authorized to terminate such blood tests or urinalysis without further action by the court.

(l) Application for an order to stay, vacate or modify. In addition to any other right or remedy available by law with respect to the order for assisted outpatient treatment, the

patient, mental hygiene legal service, or anyone acting on the patient's behalf may apply on notice to the appropriate director and the original petitioner, to the court to stay, vacate or modify the order.

(m) Appeals. Review of an order issued pursuant to this section shall be had in like manner as specified in section 9.35 of this article.

(n) Failure to comply with assisted outpatient treatment. Where in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and in the physician's clinical judgment, efforts were made to solicit compliance, and, in the clinical judgment of such physician, such patient may be in need of involuntary admission to a hospital pursuant to section 9.27 of this article, or for whom immediate observation, care and treatment may be necessary pursuant to section 9.39 or 9.40 of this article, such physician may request the director, the director's designee, or persons designated pursuant to section 9.37 of this article, to direct the removal of such patient to an appropriate hospital for an examination to determine if such person has a mental illness for which hospitalization is necessary pursuant to section 9.27, 9.39 or 9.40 of this article. Furthermore, if such assisted outpatient refuses to take medications as required by the court order, or he or she refuses to take, or fails a blood test, urinalysis, or alcohol or drug test as required by the court order, such physician may consider such refusal or failure when determining whether the assisted outpatient is in need of an examination to determine whether he or she has a mental illness for which hospitalization is necessary. Upon the request of such physician, the director, the director's designee, or persons designated pursuant to section 9.37 of this article, may direct peace officers, when acting pursuant to their special duties, or police officers who are members of an authorized police department or force or of a sheriff's department to take into custody and transport any such person to the hospital operating the assisted outpatient treatment program or to any hospital authorized by the director of community services to receive such persons. Such law enforcement officials

shall carry out such directive. Upon the request of such physician, the director, the director's designee, or person designated pursuant to section 9.37 of this article, an ambulance service, as defined by subdivision two of section three thousand one of the public health law, or an approved mobile crisis outreach team as defined in section 9.58 of this article shall be authorized to take into custody and transport any such person to the hospital operating the assisted outpatient treatment program, or to any other hospital authorized by the director of community services to receive such persons. Such person may be retained for observation, care and treatment and further examination in the hospital for up to seventy-two hours to permit a physician to determine whether such person has a mental illness and is in need of involuntary care and treatment in a hospital pursuant to the provisions of this article. Any continued involuntary retention in such hospital beyond the initial seventy-two hour period shall be in accordance with the provisions of this article relating to the involuntary admission and retention of a person. If at any time during the seventy-two hour period the person is determined not to meet the involuntary admission and retention provisions of this article, and does not agree to stay in the hospital as a voluntary or informal patient, he or she must be released. Failure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court.

(o) Effect of determination that a person is in need of assisted outpatient treatment. The determination by a court that a patient is in need of assisted outpatient treatment under this section shall not be construed as or deemed to be a determination that such patient is incapacitated pursuant to article eighty-one of this chapter.

(p) False petition. A person making a false statement or providing false information or false testimony in a petition or hearing under this section is subject to criminal prosecution pursuant to article one hundred seventy-five or article two hundred ten of the penal law.

(q) Exception. Nothing in this section shall be construed to affect the ability of the

director of a hospital to receive, admit, or retain patients who otherwise meet the provisions of this article regarding receipt, retention or admission.

(r) Educational materials. The office of mental health, in consultation with the office of court administration, shall prepare educational and training materials on the use of this section, which shall be made available to local governmental units as defined in article forty-one of this chapter, providers of services, judges, court personnel, law enforcement officials and the general public.

§ § 7. Subdivision (h) of section 9.61 of the mental hygiene law, as amended by chapter 338 of the laws of 1999, is amended to read as follows:

(h) Applications for additional periods of treatment. If the director of such hospital determines that the condition of such patient requires further involuntary outpatient treatment, the director shall apply prior to the earlier of April first, two thousand or the expiration of the period of involuntary outpatient treatment ordered by the court for an order authorizing continued involuntary outpatient treatment for a period not to exceed one hundred eighty days from the date of the order. The procedures for obtaining any order pursuant to this subdivision shall be in accordance with the provisions of the foregoing subdivisions of this section. The period for further involuntary outpatient treatment authorized by any subsequent order under this subdivision shall not exceed one hundred eighty days from the date of the order. ~~Provided, further~~ Notwithstanding any other provision of law, any order authorizing involuntary outpatient treatment, issued pursuant to this section shall expire on ~~August tenth, nineteen hundred ninety nine, unless otherwise provided by law~~ or before September thirtieth, two thousand.

§ § 8. Section 6 of chapter 560 of the laws of 1994, amending the judiciary law and the mental hygiene law relating to establishing a pilot program of involuntary outpatient treatment, as amended by chapter 338 of the laws of 1999, is amended to read as follows:

§ § 6. This act shall take effect immediately and shall expire ~~August 10, 1999~~ September 30, 2000 when upon such date the provisions of this act shall be deemed repealed.

§ § 9. Section 9.61 of the mental hygiene

law, as added by chapter 678 of the laws of 1994, is renumbered section 9.63. 10. Paragraph 1 of subdivision (e) of section 29.15 of the mental hygiene law, as amended by chapter 789 of the laws of 1985, is amended to read as follows:

1. In the case of an involuntary patient on conditional release, the director may terminate the conditional release and order the patient to return to the facility at any time during the period for which retention was authorized, if, in the director's judgment, the patient needs in-patient care and treatment and the conditional release is no longer appropriate; provided, however, that in any such case, the director shall cause written notice of such patient's return to be given to the mental hygiene legal service. ~~[If, at any time prior to the expiration of thirty days from the date of return to the facility, he or any relative or friend or the mental hygiene legal service gives notice in writing to the director of request for hearing on the question of the suitability of such patient's return to the facility, a hearing shall be held pursuant to the provisions of this chapter relating to the involuntary admission of a person.]~~ The director shall cause the patient to be retained for observation, care and treatment and further examination in a hospital for up to seventy-two hours if a physician on the staff of the hospital determines that such person may have a mental illness and may be in need of involuntary care and treatment in a hospital pursuant to the provisions of article nine of this chapter. Any continued retention in such hospital beyond the initial seventy-two hour period shall be in accordance with the provisions of this chapter relating to the involuntary admission and retention of a person. If at any time during the seventy-two hour period the person is determined not to meet the involuntary admission and retention provisions of this chapter, and does not agree to stay in the hospital as a voluntary or informal patient, he or she must be released, either conditionally or unconditionally.

§ § 11. Section 29.19 of the mental hygiene law, as amended by chapter 843 of the laws of 1980, is amended to read as follows:

§ § 29.19 Powers and duties of peace officers acting pursuant to their special duties and police officers to apprehend, restrain, and transport persons to facilities.

A person who has been committed or admitted to a department facility or a hospital licensed or operated by the office of mental

health and who has been reported as escaped therefrom or from lawful custody, or who resists or evades lawful custody; and any patient for whom the director of a hospital operated by the office of mental health, or the director's designee, has terminated a conditional release and ordered such patient to return to such facility; and any patient for whom a director of an assisted outpatient treatment program, as defined in subdivision (a) of section 9.60 of this chapter, or the director's designee, or anyone designated pursuant to section 9.37 of this chapter, has directed the removal to a hospital pursuant to subdivision (n) of section 9.60 of this chapter, may be apprehended, restrained, transported to, and returned to such school or hospital by any peace officer, acting pursuant to his special duties, or any police officer who is a member of an authorized police department or force or of a sheriff's department, and it shall be the duty of any such officer to assist any representative of a department or licensed facility, or an assisted outpatient treatment program, to take into custody any such person or patient upon the request of such representative, director or designee.

§ § 12. Subdivisions (b) and (d) of section 33.13 of the mental hygiene law, as amended by chapter 912 of the laws of 1984, are amended to read as follows:

(b) The commissioners may require that statistical information about patients or clients be reported to the offices. ~~[Names of patients treated at out patient or non-residential facilities, at hospitals licensed by the office of mental health and at general hospitals shall not be required as part of any such reports.]~~

(d) Nothing in this section shall prevent the electronic or other exchange of information concerning patients or clients, including identification, between and among (i) facilities or others providing services for such patients or clients pursuant to an approved local or unified services plan, as defined in article forty-one of this chapter, or pursuant to agreement with the department, and (ii) the department or any of its licensed or operated facilities. ~~[Information]~~ Furthermore, subject to the prior approval of the commissioner of mental health, hospital emergency services licensed pursuant to article twenty-eight of the public health law shall be authorized to exchange information concerning patients or clients electronically or otherwise with other hospital emergency services licensed pursuant to arti-

cle twenty-eight of the public health law and/or hospitals licensed or operated by the office of mental health; provided that such exchange of information is consistent with standards, developed by the commissioner of mental health, which are designed to ensure confidentiality of such information. Additionally, information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

§ § 13. Subdivision (a) of section 41.13 of the mental hygiene law is amended by adding two new paragraphs 15 and 16 to read as follows:

15. administer, supervise or operate any assisted outpatient treatment program of a local governmental unit pursuant to section 9.60 of this chapter and provide that all necessary services are planned for and made available for individuals committed under the program.

16. identify and plan for the provision of care coordination, emergency services, and other needed services for persons who are identified as high-need patients, as such term is defined by the commissioner of mental health.

§ § 14. Subdivision (c) of section 47.03 of the mental hygiene law, as added by chapter 789 of the laws of 1985, is amended to read as follows:

(c) To provide legal services and assistance to patients or residents and their families related to the admission, retention, and care and treatment of such persons, to provide legal services and assistance to subjects of a petition or patients subject to section 9.60 of this chapter, and to inform patients or residents, their families and, in proper cases, others interested in the patients' or residents' welfare of the availability of other legal resources which may be of assistance in matters not directly related to the admission, retention, and care and treatment of such patients or residents;

§ § 15. (a) Within amounts appropriated therefor, the commissioner of mental health shall provide grants to each county and the city of New York, which shall be used by each such county or city, to provide medication, and other services necessary to prescribe and administer medication to treat mental illness during the pendency of a medical assistance eligibility determination. Such eligibility determination shall be completed in a timely and

expeditious manner as required by applicable regulations of the commissioner of health. Counties or the city shall use such grants to provide medications prescribed to treat mental illness for individuals for whom the process of applying for medical assistance benefits has been commenced prior to or within one week of discharge or release and who: (1) are discharged from a hospital, as defined in section 1.03 of the mental hygiene law, or (2) have received services in or from a forensic or similar mental health unit of a correctional facility or local correctional facility as defined in section two of the correction law. (b) Such grants to provide medications shall be subject to the commissioner's approval and supervision of an efficient and effective plan submitted by a county or the city of New York. Such plans shall include, but not be limited to, the following: (i) the process by which the county or the city of New York will improve the timely and expeditious filing of medical assistance applications and coordinate the filing of applications for other public benefits for which the population described in subdivision (a) of this section may be eligible; (ii) the process by which medications prescribed to treat mental illness for such individuals will be available at or near the time of release or discharge; (iii) a specific description of the process by which such individuals will be referred to a county or city provider, or a provider which contracts with the county or city, to provide medication at or near the time of release or discharge; and (iv) the process to provide information necessary for the New York state office of mental health to file appropriate medical assistance claims.

(c) Further, upon application of a county or the city of New York, and within the amounts appropriated therefor, the commissioner of mental health shall be authorized to provide grants to such county or city to be used to assist the local governmental units, as defined in section 41.03 of the mental hygiene law, in the development of plans pursuant to subdivision (b) of this section, or to be used at local correctional facilities to improve the coordination between the individuals defined in subdivision (a) of this section and the appropriate county representative or other individual who will provide the psychiatric medications available under this program as determined in the plans approved in subdivision (b) of this section, and to assist such individuals in applying for medical assistance and other public

benefits. The commissioner of mental health is hereby authorized to promulgate and adopt rules and regulations necessary to implement this section.

§ § 16. Report and evaluation. The commissioner of mental health shall issue an interim report on or before January 1, 2003 and a final report on or before March 1, 2005. Such reports shall be submitted to the governor and the chairpersons of the senate and assembly mental health committees, and shall include information concerning the characteristics and demographics of assisted outpatients; the incidence of homelessness, hospitalization and incarceration of patients before assisted outpatient treatment to the extent available, and information on such incidence during assisted outpatient treatment; outcomes of judicial proceedings, including the percentage of petitions for assisted outpatient treatment that are granted by the court; referral outcomes, including the time frames for service delivery; reasons for closed cases; utilization of existing and new services; and recommendations for changes in statute.

§ § 17. Separability clause. If any clause, sentence, paragraph, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

§ § 18. This act shall take effect immediately, provided that section fifteen of this act shall take effect April 1, 2000, provided, further, that subdivision (e) of section 9.60 of the mental hygiene law as added by section six of this act shall be effective 90 days after this act shall become law; and that this act shall expire and be deemed repealed June 30, 2005; and, provided, further, that the amendments to section 9.61 of the mental hygiene law made by section seven of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

Appendix 2

Kendra's Law: Assisted Outpatient Treatment in New York

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INTRODUCTION

On January 3, 1999, an event occurred which galvanized the mental health community, and served as a catalyst for an effort to identify and address the needs of the small population of persons who respond well to treatment when hospitalized, but who have trouble maintaining their recovery once back in the community. On that date, Andrew Goldstein, a man with a history of mental illness and hospitalizations, pushed Kendra Webdale onto the subway tracks in a tunnel beneath the streets of Manhattan. Ms. Webdale lost her life as a result. What followed was a bi-partisan effort, led by Governor George Pataki, to create a resource delivery system for this population, who, in view of their treatment history and present circumstances, are likely to have difficulty living safely in the community.¹

On August 9, 1999, Governor Pataki signed Kendra's Law, creating a statutory framework for court-ordered assisted outpatient treatment ("AOT"), to ensure that individuals with mental illness, and a history of hospitalizations or violence, participate in community-based services appropriate to their needs.² The law became effective in November of 1999. Since that time, 4,245 court orders have been issued for AOT statewide, together with 2,559 renew-

al orders.³ The majority of orders and renewals have been issued in New York City.

The statute creates a petition process, found in Mental Hygiene Law ("M.H.L.") section 9.60, designed to identify those persons who may not be able to survive safely in the community without greater supervision and assistance than historically has been available. A description of many aspects of the petition process follows, and is in turn followed by a review of some of the more important court decisions concerning Kendra's Law.

FILING THE PETITION

Kendra's Law establishes a procedure for obtaining court orders for certain patients to receive and accept outpatient treatment.⁴ The prescribed treatment is set forth in a written treatment plan prepared by a physician who has examined the individual.⁵ The procedure involves a hearing in which all the evidence, including testimony from the examining physician, and, if desired, from the person alleged to need treatment, is presented to the court.⁶ If the court determines that the individual meets the criteria for assisted outpatient treatment ("AOT"), an order is issued to either the director of a hospital licensed or

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operated by the Office of Mental Health (“OMH”), or a director of community services who oversees the mental health program of a locality (i.e., the county or the City of New York mental health director). The initial order is effective for up to six months⁷ and can be extended for successive periods of up to one year.⁸ Kendra’s Law also provides a procedure for the removal of a patient subject to a court order to a hospital for evaluation and observation, in cases where the patient fails to comply with the ordered treatment and poses a risk of harm.⁹

The process for issuance of AOT orders begins with the filing of a petition in the supreme or county court where the person alleged to be mentally ill and in need of AOT is present (or is believed to be present). The following may act as petitioners:

- (i) any person eighteen years of age or older with whom the subject of the petition resides; or
- (ii) the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or
- (iii) the director of a hospital in which the subject of the petition is hospitalized; or
- (iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; or
- (v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or
- (vi) the director of community services, or his or her designee, or the social services official, as defined in the social services law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or
- (vii) a parole officer or probation officer assigned to supervise the subject of the petition.¹⁰

The petition must include the sworn statement of a physician who has examined the person within ten days of the filing of the petition, attesting to the need for AOT.¹¹ In the alternative, the affidavit may state that

unsuccessful attempts were made in the past ten days to obtain the consent of the person for an examination, and that the physician believes AOT is warranted. In the latter case, if the court finds reasonable cause to believe the allegations in the petition are true, the court may request that the patient submit to an examination by a physician appointed by the court, and ultimately may order peace officers or police officers to take the person into custody for transport to a hospital for examination by a physician. Any such retention shall not exceed twenty-four hours.¹²

The petitioner must establish by clear and convincing evidence that the subject of the petition meets all of the following criteria:

- 1.) He or she is at least 18 years old; and
- 2.) is suffering from a mental illness; and
- 3.) is unlikely to survive safely in the community without supervision; and
- 4.) has a history of lack of compliance with treatment for mental illness that has:
 - (a) at least twice within the last 36 months been a significant factor in necessitating hospitalization or receipt of services in a forensic or other mental health unit in a correctional facility or local correctional facility (not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition), or
 - (b) 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 48 months (not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition); and
- 5.) is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; and
- 6.) in view of his or her treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to self or others; and
- 7.) it is likely that the person will benefit from assisted outpatient treatment; and
- 8.) if the person has executed a health care proxy, any directions included in such

proxy shall be taken into account by the court in determining the written treatment plan.¹³

In addition, a court may not issue an AOT order unless it finds that assisted outpatient treatment is the least restrictive alternative available for the person.¹⁴

Notice of the petition must be served on a number of people or entities, including the person, his or her nearest relative, the AOT Program Coordinator, and the Mental Hygiene Legal Service ("MHLS"), among others.¹⁵ The court is required to set a hearing date that is no more than three days after receipt of the petition, although adjournments can be granted for good cause.¹⁶

If the court finds by clear and convincing evidence that the subject of the petition meets each of the criteria and a written treatment plan has been filed, the court may order the subject to receive assisted outpatient treatment. The order must specifically state findings that the proposed treatment is the least restrictive treatment that is appropriate and feasible, must include case management or Assertive Community Team services and must state the other categories of treatment required. The court may not order treatment which is not recommended by the examining physician and included in the treatment plan.¹⁷ Appeals of AOT orders are taken in the same manner as specified in M.H.L. section 9.35 relating to retention orders.¹⁸

If in the clinical judgment of a physician the assisted outpatient has failed or refused to comply with the treatment ordered by the court, efforts must be made to achieve compliance. If these efforts fail, and the patient may be in need of involuntary admission to a hospital, the physician may request the director of community services, his designee, or other physician designated under section 9.37 of the M.H.L. to arrange for the transport of the patient to a hospital. If requested, peace officers, police officers or members of an approved mobile crisis outreach team must take the patient into custody for transport to the hospital. An ambulance service may also be used to transport the patient. The patient may be held for up to 72 hours for care, observation and treatment and to permit a physician to determine whether

involuntary admission under the standards set forth in Article 9 of the M.H.L. is warranted.¹⁹ If, during the 72-hours a determination is made that the patient does not meet the standard for inpatient hospitalization, then the patient must be released immediately.

The legislation also provides for the exchange of clinical information pertaining to AOT patients. Kendra's Law amends M.H.L. section 33.13, the confidentiality provision, to clarify that OMH licensed or operated facilities may share confidential patient information, when such sharing is necessary to facilitate AOT.²⁰

LEGAL DEVELOPMENTS

Since the legislation became effective, New York courts have addressed a number of issues related to the statute, and have rendered decisions regarding the constitutionality of the statute, as well as decisions construing statutory provisions concerning the criteria for AOT orders, and the evidentiary standard under the statute.

Constitutional Challenges

Kendra's Law was signed into law by Governor George Pataki on August 9, 1999, and became effective on November 8, 1999. Even before the law was implemented, there emerged a focused debate concerning the issue of whether the law achieved its goal of creating a mechanism to insure that individuals who met the statutory criteria remained treatment compliant while in the community, in a way that was consistent with the Constitutional rights of those individuals.

On one side of the debate, proponents of the law recognized the numerous procedural aspects of the law which were included specifically to meet constitutional standards, many of which were deliberately modeled after other provisions of the Mental Hygiene Law, which themselves had survived prior judicial scrutiny and had been found to be constitutional. The supporters of the law argued that any compulsion occasioned by the law was justified by the law's important objective of helping individuals with a history

of treatment non-compliance resulting in violent acts and/or repeated hospitalization, to live safely in the community.

On the other side of the debate, opponents of the law primarily relied upon prior judicial decisions which found that forcible medication over objection required a finding of incapacity. The opponents of the law read into these decisions a much broader prescription of any measures which might influence an individual's decision to comply with treatment, even when those measures fall far short of forcible medication over objection.

This theoretical debate would not be resolved without judicial intervention and inevitably found its way into the courts.

In *In re Urcuyo*,²¹ the first court challenge to the constitutionality of Kendra's Law, the Mental Hygiene Legal Service ("MHLS") moved for dismissals on behalf of two respondents to Kendra's Law petitions in Supreme Court, Kings County. Respondents argued that Kendra's Law violated the due process and equal protection guarantees of the New York State and the United States Constitutions because the statute did not require a judicial finding of incapacity prior to the issuance of an order requiring the respondent to comply with the AOT treatment plan. The court rejected all of respondents' arguments, and held that the statute was in each respect constitutional.

The challenge was based largely upon the Court of Appeals decision in *Rivers v. Katz*.²² The *Rivers* court acknowledged that all patients have a fundamental right to determine the course of their own treatment, but also that there may be circumstances where it is necessary to administer treatment to a psychiatric inpatient over the patient's objections, pursuant to either the State's police power or *parens patriae* power. *Rivers* established a procedural due process standard for medication over objection, requiring a judicial finding that the patient lacks the capacity to make competent decisions concerning treatment. This is a judicial determination, not a clinical determination, and recognizes that there is a cognizable deprivation of liberty resulting from a decision to forcibly medicate a person who has been involuntarily committed.

Respondents in *Urcuyo* urged the court to equate the infringement of a patient's liberty interest as a consequence of an AOT order with the *Rivers* situation, where a psychiatric inpatient is forcibly medicated against his or her will. Respondents pointed to the compulsive nature of court orders, and reasoned that the threat of removal for observation as a result of non-compliance is so akin to the forcible medication situation in *Rivers*, that identical due process safeguards are constitutionally required.²³

The court answered by stating that AOT patients are not involuntary inpatients, and therefore are not even subject to medication over objection. There is no threat of medication over objection because there is no authorization in the statute for such measures, and that "[e]ven if a patient is eventually retained in a hospital after the seventy-two hour evaluation period [pursuant to 9.60(n)], he or she still cannot be forcibly medicated absent a judicial determination of incapacity or under emergency circumstances."²⁴

With respect to respondents' attempts to draw analogies between forcible administration of medication over objection, and the more remote possibility of clinical intervention in the event of non-compliance, the response was equally succinct:

This court rejects respondents' argument that an assisted outpatient order, while not providing for the forcible administration of medication, unreasonably violates the patient's right to refuse medication by threatening arrest upon non-compliance with the plan. . . . the court does not agree with respondents' argument that a failure to take medication results in the summary arrest of the patient. Rather, the patient's failure to comply with the treatment plan, whose formulation the patient had the opportunity to participate in, leads to the heightened scrutiny of physicians for a 72-hour evaluation period, but only after a physician has determined that the patient may be in need of involuntary admission to a hospital.²⁵

Ultimately, the 72-hour observation period was held to be "a reasonable response to a patient's failure to comply with treatment

when it is balanced against the compelling State interests which are involved."²⁶ Furthermore, the removal and 72-hour observation provisions of the statute were held to be in accord with earlier judicial constructions of the dangerousness standard embodied in the M.H.L. provisions concerning involuntary commitment.

One such precedent was Project Release v. Provost,²⁷ which held that M.H.L. provisions authorizing involuntary observation periods of up to 72 hours satisfy constitutional due process standards. Reference was also made to prior decisions permitting clinicians, and courts, to consider a patient's history of relapse or deterioration in the community, when weighing the appropriateness of an exercise of the police power or the *parens patriae* power. For example, Matter of Seltzer v. Hogue²⁸ involved a civilly committed patient whose behavior improved in the hospital, but who would not comply with treatment, and whose condition would deteriorate in the community. The Hogue court considered evidence of the patient's behavior in the community, and pattern of treatment failures, and ordered his continued retention under M.H.L. section 9.33. Relying on Hogue, the Urcuyo court held that it was appropriate to consider the patient's behavior in the community, and any history of treatment failures, when making a determination regarding dangerousness in a proceeding pursuant to Kendra's Law.²⁹

Reviewing the specific criteria that must be shown by a petitioner, the high evidentiary standard requiring that those criteria be shown by clear and convincing evidence, and the prior judicial acceptance of other Mental Hygiene Law provisions which are analogous to the 72-hour observation provision of Kendra's Law, the court found respondents' constitutional due process rights are sufficiently protected.

Although the constitutional issues considered by the court were sufficiently significant that an appeal of the decision would appear to have been a certainty, the particular facts of the case resulted in a withdrawal of the petition prior to a final decision on the merits. Consequently the parties were deprived of standing to bring the court's decision concerning the issue of the law's constitutionality

before the Appellate Division, and thus appellate review of the issue would have to wait for a more suitable case.

It did not take long for such a case to arise for in the wake of the decision in Matter of Urcuyo, the Supreme Court, Queens County, was presented with another constitutional challenge to Kendra's Law. In Matter of K.L.,³⁰ the MHLS moved for dismissal of a petition on behalf of respondent, arguing that the statute was unconstitutional on two grounds — that the statute unconstitutionally deprived patients of the fundamental right to determine their own course of treatment, and that the statutory provisions concerning removal for observation following non-compliance with the AOT order are facially unconstitutional. The Attorney General of the State of New York, in his statutory capacity under N.Y. Exec. Law s. 71 intervened to support the constitutionality of the statute. In turn, an *amici* brief was submitted in support of the respondent's constitutional challenge, representing a number of advocate groups.

The first challenge brought by the respondent in Matter of K.L. echoed the constitutional challenge in Matter of Urcuyo, and asked the court to equate AOT with the type and degree of deprivation of liberty implicated in Rivers, which involved the forcible medication of a psychiatric inpatient over the patient's objection.³¹ Respondent argued that in those cases where the treatment plan included a medication component, the court could avoid finding the statute unconstitutional by construing it to require a judicial finding that the patient lacked the capacity to make reasoned decisions concerning his medical treatment. Respondent offered that the procedural safeguards developed in Rivers could be imported into the AOT procedure, and preserve the patient's right to control his course of treatment.

Respondent's characterization of Kendra's Law orders as tantamount to medication over objection was rejected, and the Rivers facts distinguished from the AOT situation. Notably, Rivers reaffirmed the right of every individual to determine his or her own course of treatment, but also recognized that "this right is not absolute, and must perforce

yield to compelling state interests when the state exercises its police power (as when it seeks to protect society), or its *parens patriae* power (to provide care for its citizens who are unable to care for themselves because of mental illness).³² The court then rejected the *Rivers* analogy:

However, there is a fundamental flaw in respondent's position in this regard. Under Kendra's Law, the patient is not required to take any drugs, or submit to any treatment against his will. To the contrary, the patient is invited to participate in the formation of the treatment plan. When released pursuant to an assisted outpatient treatment order, no drugs will be forced upon him if he fails to comply with the treatment plan.³³

After dismissing the *Rivers* analogy, the court went on to analyze whether any deprivation of a patient's liberty interests occasioned by a Kendra's Law order was the result of the constitutional exercise of the State's police or *parens patriae* powers. The court first noted that for the state to exercise the police power where an individual's liberty interest may be infringed, a compelling state interest must be identified. The court found such a compelling state interest:

Certainly, the state has a compelling interest in preventing emergencies and protecting the public health. Thus the objective of Kendra's Law, the outpatient treatment of the mentally ill who, without treatment, "may relapse or become suicidal," may be viewed as a reasonable motive for the exercise of the state's police power.³⁴

The court noted that the statute requires that a history of non-compliance leading to repeated hospitalizations, or serious violent behavior toward the individual himself or others, and that a relapse in the individual's illness would be likely to result in serious harm to the patient or others, and concluded that "[t]hese considerations are not trivial."³⁵ Ultimately, the court found that these considerations demonstrated the appropriateness of the state's exercise of its *parens patriae* powers as well.³⁶

In light of exhaustive legislative findings, and "elaborate procedural safeguards to insure the protection of the patient's rights,"³⁷ the court concluded:

Given that the purpose of Kendra's Law is to protect both the mentally disabled individual and the greater interests of society, the statute is narrowly tailored to meet its objective. In view of the significant and compelling state interests involved, the statute is not overly broad, or in any way unrelated to, or excessive in light of those interests.³⁸

Respondent's second constitutional challenge was based upon the contention that, in order for the removal provision (M.H.L. section 9.60(n)) to pass constitutional muster, the patient must be afforded notice and an opportunity to be heard prior to any removal for observation. Or stated differently, "it is urged that only a court may order such confinement or detention, rather than a physician, as set forth in the statute."³⁹ This argument was also rejected.

Contrary to respondent's position that the statute permits summary arrest without any due process, for an AOT order to issue in the first instance there must have been a judicial finding, based on clear and convincing evidence, that in the event of a failure to comply with treatment, the patient will likely present a danger to himself or others. In addition to this prior judicial finding, failure to comply does not automatically result in the immediate confinement of the patient. In fact, the court went to great lengths to articulate the significant procedural requirements which must be met prior to any effort to remove the patient who has failed to comply with his treatment plan:

Before a physician may order [removal] of a patient to a hospital for examination, the following must take place:

1. The physician must be satisfied that efforts were made to solicit the patient's compliance; and
2. In the clinical judgment of the physician, the patient (a) "may be in need of involuntary admission to a hospital pursuant to section 9.27 of the mental hygiene law;" or (b) "immediate observation, care and

- treatment of the patient may be necessary pursuant to Mental Hygiene Law sections 9.39 or 9.40.” Then,
3. The physician may request “the director,” or certain other specific person, to direct the removal of the patient to an appropriate hospital for examination, pursuant to specific standards.
 4. The patient may be retained only for a maximum of 72 hours.
 5. If at any time during the 72-hour period the patient is found not to meet the involuntary admission and retention provision of the Mental Hygiene Law, he must be released.⁴⁰

With reference to other provisions of the Mental Hygiene Law which permit the involuntary removal of a person to a hospital, and which have all been constitutionally upheld,⁴¹ the court noted that the removal provisions in Kendra's Law contemplate even greater procedural protections. For example, removal under Kendra's Law requires a prior judicial finding that removal may be appropriate in the event of failure to comply.

Having had his constitutional challenge to Kendra's Law denied by the supreme court in Queens County, and having had that court also grant the petition for assisted outpatient treatment as to him, the Respondent in *Matter of K.L.* appealed the decision to the Appellate Division, Second Department. Although the order for assisted outpatient treatment had expired by the time the appeal was heard, the Second Department found that the issues raised justified invocation of an exception to the mootness doctrine.⁴² The Appellate court also rejected arguments by the Attorney General that Respondent lacked standing to challenge the removal provisions of the law, because he had failed to allege that he had actually been removed pursuant to that provision in violation of his constitutional rights.⁴³

In an opinion notable for its succinctness, the Second Department also rejected the argument that the additional procedural due process created by *Rivers v. Katz* applicable to forcible medication over objection also preclude court-ordered assisted outpatient treatment such as is permitted by Kendra's Law. In a unanimous opinion, the court held:

In contrast to *Rivers*, however, Kendra's Law is based on a legislative finding that there are some mentally-ill persons who are “capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization”. . . . Any compulsion that the patient feels to comply with the treatment plan is justified by the court's finding, by clear and convincing evidence, that the patient needs AOT in order to prevent a relapse or deterioration which is likely to cause serious harm to the patient or others. (Under these circumstances, a judicial finding of incapacity is not warranted⁴⁴

The Second Department then identified three separate challenges to the removal provision of Kendra's Law. First, Respondent alleged that the removal provision failed to meet constitutional procedural due process standards, because it did not require a pre-removal judicial hearing. The court applied the test established by the U.S. Supreme Court in *Mathews v. Eldridge*,⁴⁵ which requires the weighing of three factors: 1.) The private interest that will be affected, 2.) The risk of an erroneous deprivation through current procedures and probable value of substitute procedures, and 3.) The government's interest, including the function involved and the burdens associated with any substitute procedures. Applying this test, the law was found to comport with constitutional due process standards:

Here, the brief detention of a noncompliant assisted outpatient for a psychiatric evaluation does not constitute a substantial deprivation of liberty, and the additional safeguard of a judicial hearing will not significantly reduce the possibility of an erroneous removal decision. Moreover, the government has a strong interest in avoiding time-consuming judicial hearings, which require mental health professionals to defend their clinical decisions and divert scarce resources from the diagnosis and treatment of the mentally ill Also, any detention beyond the initial 72 hours is governed by the statutory provisions for

involuntary commitments, which contain sufficient notice and hearing provisions to meet “procedural due process minima” (*Project Release v Prevost*, 722 F.2d 960, 975).⁴⁶

Respondent next challenged the removal provision by arguing that since CPL 330.20(14) provides criminal defendants who are found not guilty by reason of mental disease or defect with the right to a hearing before being recommitted to a secure psychiatric facility, that a person subject to a Kendra's Law order is deprived of their equal protection rights because they do not have a similar right to a hearing. This position was quickly rejected, because the situation of an insanity acquittee is sufficiently distinct from that of an individual subject to civil commitment.⁴⁷

Finally, the argument that removal pursuant to the statute violates the Fourth Amendment to the United States Constitution because it does not require a finding of probable cause was also rejected. The statute requires a physician to make several determinations based upon clinical judgment, mirroring the provisions of M.H.L. 9.13, which in turn contains a “reasonable grounds” standard:

Under these circumstances, a physician's clinical judgment based on the statutory criteria is sufficient to justify the removal and detention of a non-compliant assisted outpatient for a 72-hour psychiatric evaluation.⁴⁸

Respondent was unsatisfied with the Appellate Division's rejection of his constitutional challenges, and made a final appeal to the New York State Court of Appeals. In February of 2004 in a unanimous opinion written by Chief Judge Judith Kaye, the highest court, like the trial court and the Appellate Division before it, rejected all of Respondent's challenges and upheld the constitutionality of the statute in all respects.⁴⁹

Once again, Respondent argued that the law could be saved if the court read into it the requirement that AOT was only permissible if there was a judicial determination that the subject lacked capacity to make treatment decisions. This argument has as its fundamental premise the notion that AOT is in fact a type of medication over objection, and

equates the impact of AOT on the subject's liberty interest with the infringement of liberty suffered by a psychiatric inpatient who is subject to forcible medication over objection. In other words, respondent argues that AOT is prohibited by *Rivers v. Katz*, in the absence of the additional procedural due process mandated by that case.

The Court of Appeals rejected this argument, acknowledging that limiting AOT to those who lacked capacity “would have the effect of eviscerating the legislation,” and that “a large number of patients potentially subject to assisted outpatient treatment would be ineligible for the program if a finding of incapacity were required.”⁵⁰ The very impetus for the law was the finding by the Legislature that many patients are capable of living safely in the community only with the benefit of the structure and supervision of AOT, and to require a finding of incapacity would in essence exclude most of the individuals the Legislature sought to assist.

The Court of Appeals quickly identified the critical flaw in Respondent's reasoning - the failure to apprehend that the additional due process required by *Rivers* is not applicable to AOT simply because medication over objection is not authorized by Kendra's Law:

Since Mental Hygiene Law § 9.60 does not permit forced medical treatment, a showing of incapacity is not required. Rather, if the statute's existing criteria satisfy due process — as in this case we conclude they do — then even psychiatric patients capable of making decisions about their treatment may be constitutionally subject to its mandate.... As we made clear in *Rivers*, the fundamental right of mentally ill persons to refuse treatment may have to yield to compelling state interests (67 NY2d at 495). The state “has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill” (*Addington v Texas*, 441 US 418, 426 [1979]). Accordingly, where a patient presents a danger to self or others, the state may be warranted, in the exercise of its police power interest in preventing violence and maintaining order, in mandating treatment over the patient's

objection. Additionally, the state may rely on its *parens patriae* power to provide care to its citizens who are unable to care for themselves because of mental illness (see *Rivers*, 67 NY2d at 495).⁵¹

Respondent also urged the court to adopt the position that even if Kendra's Law did not permit forcible medication over objection, the fact that AOT subjects are ordered by a judge to take their medication may prompt a subjective response from the individual amounting to coercion which is so substantial as to be considered equivalent to forcible medication. This argument was likewise summarily rejected:

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.⁵²

Considering the high evidentiary burden faced by AOT petitioners, and the detailed criteria in the statute and the considerable and important interests of the state in insuring the safety of the AOT subject as well as others in the community, the court concluded that the individual's right to refuse treatment was not unconstitutionally infringed:

In any event, the assisted outpatient's right to refuse treatment is outweighed by the state's compelling interests in both its police and *parens patriae* powers. Inasmuch as an AOT order requires a specific finding by clear and convincing evidence that the patient is

in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to self or others, the state's police power justifies the minimal restriction on the right to refuse treatment inherent in an order that the patient comply as directed. Moreover, the state's interest in the exercise of its police power is greater here than in *Rivers*, where the inpatient's confinement in a hospital under close supervision reduced the risk of danger he posed to the community. In addition, the state's *parens patriae* interest in providing care to its citizens who are unable to care for themselves because of mental illness is properly invoked since an AOT order requires findings that the patient is unlikely to survive safely in the community without supervision [and] . . . the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others . . . In requiring that these findings be made by clear and convincing evidence and that the assisted outpatient treatment be the least restrictive alternative, the statute's procedure for obtaining an AOT order provides all the process that is constitutionally due.⁵³

The argument that an individual's constitutional equal protection rights are violated in the absence of a finding of incapacity, because persons subject to guardianship proceedings, and involuntarily committed inpatients must be accorded such a hearing prior to medication over objection, was also rejected. Reiterating that Kendra's Law simply does not authorize medication over objection, the court held that "[t]he statute thus in no way treats similarly situated persons differently."⁵⁴

Respondent also challenged the removal provision of Kendra's Law, contending that because the law does not require a pre-removal hearing that the individual's constitutional due process rights are violated. The statute permits the temporary removal of an individual subject to an AOT order, if the individual is non-compliant with treatment, efforts to solicit compliance have failed, and a physician determines that as a result the

individual may be in need of inpatient care and treatment. The individual may be retained for up to 72 hours to determine whether he or she meets the standards for further retention found in any of a number of other provisions of the Mental Hygiene Law. If at any time during the 72 hours it is determined that the individual does not meet the standards for further retention, he or she must be released.

The Court of Appeals, like the Appellate Division, applied the balancing test announced in the United States Supreme Court case, *Mathews v. Eldridge*. The court balanced the interest affected, the risk of deprivation through the procedures in the law and the burden of alternative procedures, and the government's interests served by the law.

Applying the first factor of this test to the removal provision of Kendra's Law, the Court of Appeals voiced disagreement with the Appellate Division, and found that the 72 hour retention did constitute a substantial deprivation of liberty. However, the Court of Appeals affirmed the lower court's ultimate conclusion that considering the *Mathews* factors together, any infringement is outweighed by the considerable procedural safeguards and the very important governmental interest at stake.⁵⁵

With respect to the second factor, the risk of an erroneous deprivation is minimized by the fact that there must be a judicial finding, by clear and convincing evidence that, among other things, "the patient is unlikely to survive safely in the community without supervision; has a history of noncompliance resulting in violence or necessitating hospitalization; and is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm." In addition, the law allows the individual's treating physician to determine the need for observation and inpatient care, which are clinical determinations, and not a judge, as Respondent urged. Considering these features of the law, the court concluded that "[a] pre-removal hearing would therefore not reduce the risk of erroneous deprivation."⁵⁶

Lastly, the governmental interest in reducing the risk of harm to the individual or others

in the community was considered to be significant, and the addition of a pre-removal hearing to the already substantial procedural safeguards would have the undesired effect of frustrating that intent:

In addition, the state's interest in immediately removing from the streets noncompliant patients previously found to be, as a result of their noncompliance, at risk of a relapse or deterioration likely to result in serious harm to themselves or others is quite strong. The state has a further interest in warding off the longer periods of hospitalization that, as the Legislature has found, tend to accompany relapse or deterioration. The statute advances this goal by enabling a physician to personally examine the patient at a hospital so as to determine whether the patient, through noncompliance, has created a need for inpatient treatment that the patient cannot himself or herself comprehend. A pre-removal judicial hearing would significantly reduce the speed with which the patient can be evaluated and then receive the care and treatment which physicians have reason to believe that the patient may need. Indeed, absent removal, there is no mechanism by which to force a noncompliant patient to attend a judicial hearing in the first place.⁵⁷

The last argument raised by Respondent alleged that removal pursuant to the law as violated of the fourth amendment prohibition against unreasonable searches and seizures, because the statute does not specify that a physician must have probable cause to believe that an individual meets the criteria for removal. The court in essence concluded that the proper exercise of clinical judgement by the physician implies that such judgments will conform with the reasonableness standard:

It is readily apparent that the requirement that a determination that a patient may need care and treatment must be reached in the "clinical judgment" of a physician necessarily contemplates that the determination will be based on the physician's reasonable belief that the patient is in need of such care.⁵⁸

As a result of the Court of Appeals decision, it is now well settled that Kendra's Law is in

all respects a constitutional exercise of the State's police power, and its *parens patriae* power. Further, the removal provisions of the law have withstood constitutional scrutiny. Because this opinion was rendered by the Court of Appeals, which is the highest court in New York, the doctrine of *stare decisis* should preclude similar facial challenges to the constitutionality of Kendra's Law in the future.

Decisions Construing the Statutory Criteria

In addition to the decisions concerning constitutional issues in *Matter of K.L.*, and *Matter of Urcuyo*, there is now some guidance from the courts concerning the statutory criteria for Kendra's Law orders, M.H.L. section 9.60(c).

Soon after the statute became effective, an issue arose with respect to the proper construction of the alternative criteria concerning a respondent's prior need for hospitalization, or prior violent acts. Among other criteria, a Kendra's Law petitioner must demonstrate under M.H.L. section 9.60(c)(4):

[that] the patient has a history of lack of compliance with treatment for mental illness that has:

- (i) 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 mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition or:
- (ii) 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 period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition . . .

The Two Hospitalization Criteria

The first prong of 9.60(c)(4) is satisfied when a petitioner demonstrates that a patient has been hospitalized twice, as a result of treatment failures, within the past thirty-six months (referred to as the "two hospitalizations" criterion). The thirty-six month look-back period excludes the duration of any current hospitalization.

In June of 2000, a Kendra's Law petition was brought in Supreme Court, Richmond County, alleging that the respondent had been hospitalized on two occasions within the statutory look-back period — within the time period of the current hospitalization plus thirty-six months.

In *Matter of Sarkis*,⁵⁹ the respondent moved to dismiss the petition, arguing, among other grounds, that the petition was deficient because it counted the current hospitalization as one of the two hospitalizations required to satisfy 9.60(c)(4)(i). Respondent reasoned that the statutory language which excluded the duration of the current hospitalization from the look-back period, must also be construed to exclude the current hospitalization from being counted as one of the two hospitalizations required.

The court relied on the specific language of the statute, and rejected respondent's argument:

[R]espondent's position is based on a flawed interpretation of the statutory provision, which reads [9.60(c)(4)(i)] as modifying the single word "hospitalization" appearing in the first clause of Mental Hygiene Law 9.60(c)(4), rather than the grammatically more consistent "thirty-six months" period during which the noncompliance resulting in such hospitalizations must occur.⁶⁰

It is the duration of the current hospitalization which is excluded from the look-back period. In any event, it is the need for hospitalization as a result of noncompliance which is at the bottom of the two hospitalization requirement. "The triggering event for purposes of Mental Hygiene Law 9.60(c)(4)(i) is not the hospital admission but rather the noncompliance with treatment necessitating

the hospitalization, and is complete before the hospitalization begins.”⁶¹

Respondent appealed the denial of his motion to dismiss, and the Appellate Division, Second Department affirmed, writing:

[W]e agree with the Supreme Court's interpretation of Mental Hygiene Law s. 9.60(c)(4)(i) . . . The appellant interprets this provision as precluding the consideration of his hospitalization immediately preceding the filing of the petition as one of the two required hospitalizations due to noncompliance with treatment within the last 36 months. . . . we reject the appellant's interpretation . . . which would inexplicably require courts to disregard the most recent incident of hospitalization due to noncompliance with treatment in favor of incidents more remote in time.⁶²

The decision in *Matter of Dailey*,⁶³ is in accord with *Matter of Sarkis*. In *Dailey*, the court rejected an argument identical to that offered by respondent in *Sarkis*, holding that reading the statutory language, together with the legislative history, “leads to the conclusion that the section seeks only to expand the number of months which a petitioner can look back to thirty-six months prior to the current hospitalization and *does not exclude* the acts of non-compliance with treatment and the current hospitalization itself from consideration for an AOT order.”⁶⁴

In a decision further clarifying the two hospitalization criteria, Supreme Court, Suffolk County held that in determining whether a particular hospitalization falls within the statutory look back period, a petitioner may rely upon the latest date of the hospitalization, and not the starting date. In *Matter of Anthony F.*, the earlier hospitalization began more than thirty-six months prior to the petition, but ended less than thirty-six months prior to the petition. The court stated that as long as the petitioner can establish a nexus between the continued hospitalization and a lack of compliance with treatment, the “thirty-six month period is to be measured from the final date of the earlier hospitalization.”⁶⁵

The Violent Act Criteria

The second prong of 9.60(c)(4) is satisfied when a petitioner establishes that a patient has committed 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 (referred to as the “violent act” criterion). However, in language which is similar to the two hospitalizations requirement discussed above, the forty-eight month look-back period excludes the duration of any current hospitalization or incarceration.

This provision of the statute was the subject of an appeal to the Second Department. In *Matter of Hector A.*,⁶⁶ the trial court had dismissed the petition because the violent act relied upon to satisfy the statutory criteria occurred while the patient was hospitalized. The respondent stabbed a hospital worker during his current hospitalization, and the outcome of the case hinged on whether the stabbing could be used to satisfy the violent act criterion of 9.60(c)(4). On appeal, petitioner argued that the forty-eight month exclusion applies only to the duration of the look-back period, and should not be read to exclude violent acts occurring during the current hospitalization. The respondent argued that the language excluding the duration of the current hospitalization from the forty-eight month look-back period also required the court to exclude evidence of any violent acts or threats during the current hospitalization. The Second Department reversed the trial court's dismissal, and held that the evidence related to the stabbing was admissible to satisfy the violent act requirement:

There is no merit to the patient's argument that the violent act he committed against a hospital employee must be disregarded under Mental Hygiene Law s. 9.60(c)(4)(ii). This provision simply extends the 48 month period for considering the patient's violent behavior by the duration of his hospitalization or incarceration “immediately preceding the filing of this petition”. This provision in no way eliminates from consideration violent acts occurring during the hospitalization or incarceration.⁶⁷

Hector A. cited with approval the rationale articulated in *Julio H.*,⁶⁸ where Respondent sought dismissal of an AOT petition, and argued for a construction of 9.60(c)(4)(ii) which would exclude violent acts which occur while a person is hospitalized from being used to satisfy the requirements of that section in an AOT petition.

The respondent in *Matter of Julio H.* moved for dismissal of the AOT petition on two grounds: First, he argued that the exclusion of the current hospitalization from the forty-eight month look back period also excludes any violent acts during the current hospitalization. Second, he urged the Court to accept the premise that a person who is currently hospitalized is receiving treatment, is therefore deemed compliant, and thus violent acts occurring during hospitalization could never be the result of non-compliance with treatment.

Both arguments were rejected, with the result that respondent's violent act occurring during his current hospitalization could be used to satisfy the violent act criterion of M.H.L. 9.60(c)(4)(ii). Further, there is no irrebuttable presumption of compliance during hospitalization, and the issue of whether a patient has been non-compliant with treatment while in a psychiatric hospital "is a fact to be determined at the AOT hearing."⁶⁹ This is significant, because the petitioner must establish a nexus between the patient's violent behavior and his failure to comply with treatment. By denying respondent's argument that compliance in the hospital is presumed, the court created an opportunity for petitioners to demonstrate a nexus between non-compliance, and violence, based on the patient's behavior while hospitalized.⁷⁰

Decisions on the Applicability of the Physician-Patient Privilege

In addition to challenges to the constitutionality of Kendra's Law, and clashes over the appropriate construction of the two hospitalizations and violent act criteria, there have been challenges involving the type of evidence which may, or must be offered in support of an AOT petition.

One significant evidentiary challenge involved the practice of having a patient's treating physician testify at the mandatory hearing on the petition. The practice prompted objections based on the physician-patient privilege, which is codified in N.Y. Civ. Prac. L. & R. ("CPLR") 4504.

Supreme Court, Queens County, was faced with such a challenge in the Spring of 2000, in *Matter of Nathan R.*,⁷¹ and ultimately ruled that the statutory privilege did not operate to prevent a treating physician from also fulfilling the role of examining physician in a Kendra's Law proceeding.

To meet the statutory requirements for AOT, a petition must be accompanied by an affidavit by an "examining physician," who must state that he or she has personally examined respondent no more than 10 days prior to the submission of the petition, that such physician recommends AOT, and that the physician is willing and able to testify at the hearing on the petition.⁷² The examining physician is also required to testify at the hearing on the petition concerning the facts underlying the allegation that the respondent meets each of the AOT criteria, that it is the least restrictive alternative, and concerning the recommended treatment plan.⁷³

In *Nathan R.*, the examining physician was also respondent's treating physician. Respondent moved to dismiss the petition, on the basis that "the physician-patient evidentiary privilege codified in CPLR 4504 absolutely prohibits a treating psychiatrist from submitting an affidavit or giving testimony in support of [an AOT] petition."⁷⁴ The motion to dismiss was denied:

CPLR 4504 does not prevent a treating physician from disclosing information about the patient under all circumstances. . . . The protection of the physician-patient privilege extends only to communications and not to facts. A fact is one thing and a communication concerning that fact is an entirely different thing.⁷⁵

The decision allowed that there may in fact be specific communications which are entitled to protection, but the burden is on the movant to demonstrate the existence of cir-

cumstances justifying the recognition of the privilege. Even in such cases, the privilege will only be held to attach to specific communications, and broad, conclusory claims of privilege, such as those made by respondent's counsel in Nathan R., will not suffice.⁷⁶

Respondent also suggested that because a treating physician is among those enumerated who may bring a petition, and a petitioner cannot also act as the examining physician, a treating physician is statutorily prohibited from fulfilling the role of examining physician. This argument was also rejected:

It is unclear whether the [respondent] is also claiming that Mental Hygiene Law s.9.60 prohibits a treating psychiatrist from being the examining physician. It does not. It only prevents a treating psychiatrist from being the petitioner if the treating psychiatrist is the examining physician.⁷⁷

Supreme Court, Queens County, was faced with an identical argument, in a motion to dismiss a Kendra's Law petition shortly after Nathan R. was decided. In Amin v. Rose E.,⁷⁸ respondent urged the court to dismiss the petition as insufficient, because the respondent's treating physician was also the examining physician, and therefore his testimony in support of the petition would be prohibited by the physician-patient privilege. In denying the motion, the court looked at, among other things, the legislative history of Kendra's Law, and held:

[I]t is clear that the legislature intended and desired for the subject's treating physician to be intimately involved with the various aspects of assisted outpatient treatment, and thereby implicitly waived the physician-patient privilege for the purposes of assisted outpatient treatment... Indeed, it would serve no useful purpose to insist on the physician-patient privilege under M.H.L. 9.60, and, in fact, would frustrate the clear intention of the legislature to keep mentally ill persons in the community and out of inpatient psychiatric hospitalization. Furthermore, once the privilege is waived, it is waived for all purposes... This clearly includes allowing the treating psychiatrist to examine the subject

of the AOT proceeding, and to testify as to his findings at that hearing.⁷⁹

Therefore, although the statute prohibits a treating physician from being both the petitioner and the examining physician with respect to a particular patient, the statute does not prohibit the treating physician from also being either the examining physician or the petitioner.

The respondent in Amin appealed the decision denying her motion to dismiss. The original petitioner did not file a responsive brief or otherwise oppose the appeal, because by the time of the appeal, the respondent was no longer in petitioner's care, and therefore petitioner did not identify itself as having any real stake in the outcome. The Attorney General was granted permission by the Appellate Division to file an amicus brief, and argued for an affirmation, based on the reasoning in Nathan R., and Amin. However, because the respondent in Amin entered into a voluntary agreement upon expiration of the original order, the appeal was dismissed as academic.⁸⁰ It is thus left to a future litigant to challenge the concurrent reasoning of Nathan R. and Amin.

Other Decisions

In Matter of Jason L.,⁸¹ a case before the Supreme Court, Monroe County, a dispute evolved concerning whether a respondent has the right to a hearing before an order can issue for his removal to a hospital for the purposes of the pre-petition examination. Even after the court formally requested that respondent submit to such an examination, he refused. Instead, respondent objected to the request, demanding that he be provided with a hearing prior to any court-ordered examination, and that to do otherwise would violate his constitutional due process rights. Relying on M.H.L. 9.60(h)(3), which governs situations where a patient refuses to permit an examination by a physician, the court ordered the removal for examination:

The court rejects respondent's contention that the statute implies the requirement of such a hearing, although in some cases it may be appropriate to do so. [The petition] suf-

ficiently sets out grounds establishing reasonable cause to belief that the petition is true. The respondent was given ample opportunity to be heard at oral argument with respect to the petition and, indeed, plans to submit written opposition to the petition itself. However, this court feels that the statute authorizes the court to make a finding on the papers submitted when appropriate and empowers the court to authorize the police to take respondent into custody for purposes of the physician examination.⁸²

Jason L. provides guidance on the issue of the procedure for pre-hearing examinations, but leaves open the possibility that judges may find it appropriate in certain circumstances to conduct a hearing prior to ordering the removal of a patient for examination. The governing standard remains whether the affidavits and other clinical evidence offered by the petitioner establish reasonable grounds to believe that the petition is true. This is a standard which is decidedly lower than that applicable to a decision on the merits of the petition, and the court in Jason L. was prudent in not allowing the hearing on the examination issue to expand into a hearing on the petition itself.

Questions regarding the evidentiary standard applicable to AOT hearings have also found their way into the courts. For example, in Matter of Jesus A.,⁸³ respondent moved to dismiss the petition, arguing that petitioner failed to offer facts sufficient to establish that an AOT order was appropriate. The court was critical of the affidavit of the examining physician, which merely paraphrased the criteria, concluding:

Clearly, these allegations, which are nothing more than conclusions, not facts, are insufficient. It thus is the holding of this court that, as in all other cases, allegations which are nothing more than broad, simple conclusory statements are insufficient to state a claim under section 9.60 of the Mental Hygiene Law.⁸⁴

The petitioner submitted a supplemental affidavit in an attempt to cure the deficiencies found in the original. This effort also failed,

because it was not based upon "personal knowledge or upon information and belief in which event the source of the information and the grounds for the belief must be provided."⁸⁵

If it was not clear prior to Jesus A., the fog has now lifted — the petition must contain specific evidence, whether in the form of documents, affidavits or testimony, that all of the criteria are met. This burden must be carried by reference to facts, and the mere paraphrasing of the statutory language will not suffice.

There has been some controversy surrounding the question of whether the right to counsel provision of Kendra's Law⁸⁶ applies to the pre-hearing examination, which inevitably takes place prior to the filing of the petition and the official commencement of the proceeding. In Matter of Nancy H., Supreme Court, Dutchess County held that the right to counsel attaches only after the proceeding is commenced. Because the examination took place prior to the filing of the petition, which commenced the proceeding, the patient did not have the right to have her attorney present during the examination.⁸⁷ A different conclusion was reached by Supreme Court, Otsego County in Matter of Noah C.⁸⁸ In Noah C. the petitioner failed to provide notice to the respondent's counsel prior to an examination in anticipation of a renewal petition. The court held that the proceeding had been commenced by the filing of the original petition, and that therefore the right to counsel had long since attached. In dicta, the court suggested that it shouldn't matter whether the petition is for an original order or for a renewal, and that in either instance the patient's counsel should receive notice prior to any pre-hearing examination.

One last issue worthy of discussion is the amount of discretion a court may exercise in fashioning relief when deciding a Kendra's Law petition. In In re Application of Manhattan Psychiatric Center,⁸⁹ the Appellate Division, Second Department, held it is within the authority of a trial court to grant or deny a Kendra's Law petition, but is beyond its authority to order retention pursuant to other sections of the M.H.L., or order treatment other than what is included in the treatment plan.

The case involved an AOT petition for a patient who, as well as having a history of mental illness and treatment failures, had a criminal history resulting from violent behavior. After the required hearing, and upon consent of the parties, the petition was granted. However, the court held the order in abeyance, pending an independent psychiatric evaluation of respondent. Although an AOT order ultimately was issued for the patient, the trial court at one point denied the petition, based on its own determination that the patient met the criteria for continued inpatient retention (the “dangerousness standard”), and should not be returned to the community, with or without AOT.

Respondent appealed, and the Second Department decided a number of issues raised by the lower court concerning the scope of that court’s authority under the statute.⁹⁰ The first issue was whether the court may make its own determination of whether the patient meets the dangerousness standard, and was therefore beyond the reach of AOT. The Second Department responded in the negative, and held that the authority of the trial court was limited to deciding whether the statutory criteria had been met, and then either granting or denying the petition. The decision whether to release the patient is a clinical determination left, in this case, to the director of the hospital. Kendra’s Law does not provide an avenue for the subordination of that clinical judgment to a judicial determination that the patient should remain hospitalized.⁹¹

The second issue was whether M.H.L. section 9.60(e)(2)(ii), which permits the court to consider evidence beyond what is contained in the petition, also implicitly provides the authority for the court to make a judicial determination with respect to the dangerousness standard. The Second Department answered again in the negative, and held that section 9.60(e)(2)(ii) only permits the consideration of additional facts in deciding whether the statutory criteria have been met, “[i]t is not an invitation to the court to consider the issue of dangerousness in respect of a decision to release the patient.”⁹²

An issue was also raised concerning whether a court has discretion to deny a petition, where the statutory criteria have been met.

Noting that a court must deny the petition if the criteria have not been met, The Second Department concluded:

Thus, the court’s discretion runs only to the least restrictive outcome. In other words, a court may decide not to order AOT for a person who meets the criteria, but it may not decide to order AOT for a patient who does not meet the criteria.... In any event, no measure of discretion would be sufficient to permit a court to bar the release of a hospitalized patient (or, by extrapolation, to order the involuntary admission of an unhospitalized patient) as an alternative to ordering AOT, because Kendra’s Law does not place that decision before the court.⁹³

Accordingly, it is now the case that clinical decisions, such as determinations of dangerousness, are not before the court during Kendra’s Law proceedings. Judicial discretion is limited to deciding whether a petitioner has carried its burden of demonstrating that the statutory criteria are met by clear and convincing evidence, and then either granting or denying the petition.⁹⁴

CONCLUSION

While there are still many issues that may want for the clarity provided by judicial review, a number of threshold issues have been resolved since Kendra’s Law became effective. Most importantly, the statute survived constitutional challenges based upon the right to control one’s treatment. Court-ordered AOT has been distinguished from forcible medication over objection, and any fears that such forced treatment would proliferate under Kendra’s Law should be allayed by judicial recognition of the fact that forced medication over objection is never appropriate in an AOT treatment plan, and in any event cannot occur absent sufficient due process pursuant to *Rivers v Katz*.

It is currently the law that in meeting the two hospitalizations criterion, although the duration of the current hospitalization is excluded from the respective look-back period, the current hospitalization itself can be used to meet the criterion. When deciding

whether a prior hospitalization falls within the statutory look-back period, a petitioner may rely upon the latest date of the hospitalization, rather than the date of admission. Similarly, in meeting the violent act criterion, although the duration of the current hospitalization is excluded from the respective look-back period, the violent acts occurring during the current hospitalization can be used to meet the criterion.

The petitioner must marshal facts and evidence, such as testimony from those with actual knowledge, in support of the petition. Mere recitations of the criteria, in affidavit form, will not suffice. In addition, while a patient's treating physician cannot be both the petitioner and the examining physician in an AOT proceeding, the treating physician can be one or the other.

If a patient refuses to submit to an examination, the court can order the removal of the patient to a hospital for the purposes of the examination. In such a circumstance, the petitioner must meet specific criteria justifying the removal, but the patient does not have an absolute right to a pre-removal hearing.

Finally, Kendra's Law does not authorize courts to make independent determinations concerning the issue of whether a patient meets involuntary inpatient criteria, during a Kendra's Law proceeding. Statutory authority extends only to the judicial determination of whether the petitioner has met its burden of proving by clear and convincing evidence that the statutory criteria have been met, and then the court may either grant or deny the petition.

Endnotes

1. Prior to the enactment of Kendra's Law, and prior to the tragic event involving Ms. Webdale, a pilot program for assisted outpatient treatment which was operated out of Bellevue Hospital in New York City. The pilot program was enacted in 1994 and codified as Mental Hygiene Law section 9.61. The pilot program expired in 1998. Although the pilot and the current law differ in many details, the basic framework for the current statute was based upon the pilot.
2. 1999 N.Y. Laws 408.
3. Office of Mental Health Statewide AOT Report as of December 31, 2004.
4. Much of the information concerning the petition process in this article can be found at the New York State Office of Mental Health official web page, www.omh.state.ny.us, which contains a great deal of useful information about Kendra's Law.
5. M.H.L. section 9.60(i)(1).
6. M.H.L. section 9.60(h).
7. M.H.L. section 9.60(j)(2).
8. M.H.L. section 9.60(k).
9. M.H.L. section 9.60(n).
10. M.H.L. section 9.60(e)(1).
11. M.H.L. section 9.60(e)(3)(i).
12. M.H.L. section 9.60(h)(3). There has been some debate concerning the issue of whether the hearing, is a right which waivable by the patient. Although some courts may grant petitions where all parties agree to waive the hearing, the language of 9.60(h)(2), and 9.60(i)(2), which expressly prohibit the court from granting an AOT order absent the examining physician's testimony at the hearing, suggests that the hearing itself is non-waivable. Other provisions, such as 9.31 and 9.35 which create the right to a hearing in the inpatient retention context provide a procedure for the patient to request a hearing, and in the absence of such a request the hearing is deemed waived.
13. M.H.L. section 9.60(c).
14. M.H.L. section 9.60(j)(2).
15. M.H.L. section 9.60(f).
16. M.H.L. section 9.60(h).
17. M.H.L. section 9.60 (j)(2).
18. M.H.L. section 9.60(m).
19. M.H.L. section 9.60(n).
20. In December of 2000, the federal Department of Health and Human Services promulgated regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) establishing standards for the privacy of individually identifiable health information (45 C.F.R. Parts 160 and 164). The general rule established in these regulations is that individually identifiable health information cannot be used or disclosed by covered entities (e.g. providers who engage in electronic transactions) without patient consent or authorization. However, several of the listed exceptions to this requirement would permit covered entities to continue to exchange clinical information without patient consent or authorization as required by Kendra's Law and Kendra's Law court orders.
21. *In re Urcuyo*, 714 N.Y.S.2d 862 (Sup. Ct. Kings County, 2000).

22. Rivers v. Katz, 67 N.Y.2d 485 (1986).
23. In re Urcuyo, 714 N.Y.S.2d at 841-42.
24. Id., at 872, n., 3 (citations omitted).
25. Id., at 869-70.
26. Id., at 870.
27. Project Release v. Provost, 772 F.2d 960 (2d Cir., 1983)
28. Matter of Seltzer v. Hogue, 187 A.D.2d 230 (Second Dept. 1993)
29. See also, In re Francis S., 206 A.D.2d 4 (First Dept. 1995), aff'd 87 N.Y.2d 554 (1995). Francis S., like the patient in Hogue, was not dangerous in the structured environment of a hospital, but in the community failed to comply with treatment and decompensated to the point of dangerousness.
30. In the Matter of the Application of Glenn Martin. For an Order Pursuant to Section 9.60 of the Mental Hygiene Law (Kendra's Law) Authorizing Assisted Outpatient Treatment for K.L., 500748/00 (Sp. Ct., Queens County, 2000), (Order Granting Kendra's Law Petition).
31. Id., at 7.
32. Id.
33. Id.
34. Id., at 8.
35. Id., at 9.
36. Id., at 10.
37. Id., at 8.
38. Id., at 9.
39. Id., at 10
40. Id., at 11.
41. For example, M.H.L. section 9.37, which provides for removal for a 72-hour observation period upon certification by a Director of Community Services was upheld in Woe by Woe v. Cuomo, 729 F.2d 96 (2d Cir. 1984), cert. den., 469 U.S. 936. The court also cited Thomas v. Culberg, 741 F.Supp. 77 (S.D.N.Y. 1990), upholding section 9.41 of the M.H.L., which permits police officers to take into custody a person who appears to be mentally ill. The court in Matter of K.L. noted that these warrantless detention provisions were upheld, even though, unlike detentions pursuant to Kendra's Law, they do not follow from earlier judicial findings.
42. Matter of K.L., 302 A.D.2d 388, 389 (Second Dept., 2003)
43. Id.
44. Id., at 390 (citations omitted).
45. 424 U.S. 319.
46. Matter of K.L., 302 A.D.2d 388, 391.
47. Id.
48. Id., at 391-392
49. Matter of K.L., 1 N.Y.3d 362 (2004). The Court of Appeals decision, Matter of K. L., is reprinted in Appendix 3.)
50. Id., at 369.
51. Id., at 370.
52. Id.
53. Id., at 371-372.
54. Id., at 372.
55. Id.
56. Id.
57. Id., at 373-374
58. Id., At 374
59. Matter of Sarkis, (NYLJ, Aug. 18, 2000, at 29, col 6).
60. Id.
61. Id.
62. In the Matter of South Beach Psychiatric Center, etc., respondent: Andre R., 727 N.Y.S.2d 149, 150 (Second Dept. 2001), (citations omitted).
63. Matter of Dailey, 713 N.Y.S.2d 660, (Sup. Ct. Queens County, 2000).
64. Matter of Dailey, 713 N.Y.S.2d at 663 (emphasis in original).
65. In the Matter of Pilgrim Psychiatric Center v. Anthony E., 18601/01 (S.Ct. Suffolk Cty, 2002), (Order Denying Motion to Dismiss Kendra's Law Petition).
66. In the Matter of Weinstock, appellant: Hector A. (Anonymous), respondent, 733 N.Y.S.2d 243 (Second Department, 2001).
67. Id., at 245.
68. In the Matter of Weinstock, for an order Authorizing Outpatient treatment for Julio H., 723 N.Y.S.2d 617 (Sup. Ct. Kings County, 2001).
69. Id., at 619.
70. See, In the Matter of Weinstock, for an Order Authorizing Assisted Outpatient Treatment for Shali K., 742 N.Y.S.2d 447 (Sup.Ct., Kings County 2002), where the court accepted the argument that a violent act in the hospital may count under the statute, but denied the petition because petitioner failed to establish a nexus between the violent act and respondent's treatment failures.
71. In the Matter of Sullivan, for an Order Authorizing Outpatient Treatment for Nathan R., 710 N.Y.S.2d 804 (Sup Ct. Queens County, 2000).
72. M.H.L. section 9.60(e)(3)(i).
73. M.H.L. section 9.60(h)(4).
74. Matter of Nathan R., 710 N.Y.S.2d at 805 (quoting respondent's counsel).
75. Id., at 805.
76. Id., at 806.
77. Id.
78. Amin v. Rose F., (NYLJ, December 7, 2000, at 31, col 1).
79. Id.
80. In the Matter of Rose F. v. Amin, 739 N.Y.S.2d 834 (Second Dept. 2002).
81. Matter of Director of Community Services, for an Order Authorizing Assisted Outpatient Treatment for Jason L., 715

- N.Y.S.2d 833 (Sup. Ct. Monroe County, 2000).
82. *Id.*, at 189.
83. In the Matter of Sullivan, for an Order Authorizing Outpatient Treatment for Jesus A., 710 N.Y.S.2d 853 (Sup. Ct. Queens County, 2000).
84. *Id.*, at 857 (citations omitted).
85. *Id.* (Citations omitted).
86. M.H.L. section 9.60(g).
87. Matter of Nancy H., No. 125/2000 - MI (Dutchess Cty, 2000), (Order Denying Motion to Dismiss for Lack of Subject Matter Jurisdiction).
88. Matter of Noah C., No. 8598 (Otsego Cty, 2003), (Order Granting Motion to Dismiss for Failure to Notice Patient's Counsel Prior to Examination).
89. In re Application of Manhattan Psychiatric Center, 728 N.Y.S.2d 37 (Second Dept., 2001).
90. Because the court did eventually sign an AOT order for the patient, the matter would appear to be beyond appellate review, based on the mootness doctrine. The Second Department accepted the case as an exception to the mootness doctrine, because it is "likely to be repeated, it involves a phenomenon which typically evades review, and it implicates substantial and novel issues." *Id.*, at 39.
91. *Id.*, at 42.
92. *Id.*, at 43.
93. *Id.*, at 43, 44 (citations omitted).
94. See also In the Matter of Endress, for an order Authorizing Outpatient Treatment for Barry H., 732 N.Y.S.2d 549 (Sup. Ct. Onieda County, 2001). The court in Endress believed that the patient should not be released into the community at all, but citing Matter of Manhattan Psychiatric Center, reluctantly granted the AOT petition, as the most appropriate outcome, given its limited alternatives.

Appendix 3

This opinion is uncorrected and subject to revision before publication in the New York Reports.

2 No. 6 In the Matter of K. L. (Anonymous),

Appellant. Glenn Martin, &c., Respondent,

Attorney General of the State of New York, Intervenor-Respondent.

Dennis B. Feld, for appellant. Sachin S. Pandya, for intervenor-respondent.

Stephen J. McGrath, for respondent. New York Lawyers For The Public Interest, Inc., et al., amici curiae.

KAYE, CHIEF JUDGE:

On January 3, 1999, Kendra Webdale was pushed to her death before an oncoming subway train by a man diagnosed with paranoid schizophrenia who had neglected to take his prescribed medication. Responding to this tragedy, the Legislature enacted Mental Hygiene Law § 9.60 (Kendra's Law) (L 1999, ch 408), thereby joining nearly 40 other states in adopting a system of assisted outpatient treatment (AOT) pursuant to which psychiatric patients unlikely to survive safely in the community without supervision may avoid hospitalization by complying with court-ordered mental health treatment.

In enacting the law, the Legislature found that "there are mentally ill persons who are capable of living in the community with the help of family, friends and mental health professionals, but who, without routine care and treatment, may relapse and become violent or suicidal, or require hospitalization" (L 1999, ch 408, § 2). And in mandating that certain patients comply with essential treatment pursuant to a court-ordered written treatment plan, the Legislature further found that "there are mentally ill persons who can function well in the community with supervision and treatment, but who without such assistance, will relapse and require long periods of hospitalization. * * * [S]ome mentally ill persons, because of their illness, have great difficulty taking responsibility for their

own care, and often reject the outpatient treatment offered to them on a voluntary basis. Family members and caregivers often must stand by helplessly and watch their loved ones and patients decompensate” (*id.*).

Studies undertaken in other jurisdictions with AOT laws have found that outpatients subject to court orders had fewer psychiatric admissions, spent fewer days in the hospital and had fewer incidents of violence than outpatients without court orders (see Mem of Off of Atty Gen, Bill Jacket, L 1999, ch 408, at 13, citing Marvin S. Swartz et al., Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings From a Randomized Trial With Severely Mentally Ill Individuals, 156 Am J Psychiatry 1968 [1999]). Kendra’s Law was thus adopted in an effort to “restore patients’ dignity * * * [and] enable mentally ill persons to lead more productive and satisfying lives” (*id.*), while at the same time reducing the risk of violence posed by mentally ill patients who refuse to comply with necessary treatment.

In October 2000, a petition was filed seeking an order authorizing assisted outpatient treatment for respondent K.L. Respondent suffered from schizoaffective disorder, bipolar type, and had a history of psychiatric hospitalization and noncompliance with prescribed medication and treatment, as well as aggressiveness toward family members during periods of decompensation. The treatment prescribed in the proposed order included a regimen of psychiatric outpatient care, case management, blood testing, individual therapy and medication. Pursuant to the plan, respondent was required in the first instance to orally self-administer Zyprexa. If, however, he was “non-compliant with above,” the plan required that he instead voluntarily submit himself to the administration of Haldol Decanoate by medical personnel.

Respondent opposed the petition, challenging the constitutionality of Kendra’s Law in a number of respects. Supreme Court and the Appellate Division rejected each of respondent’s constitutional arguments, as do we.

I.

Before a court may issue an order for assisted outpatient treatment, the statute requires that a hearing be held at which a number of criteria must be established, each by clear and convincing evidence. The court must find that (1) the patient is at least 18 years of age; (2) the patient suffers from a mental illness; (3) the patient is unlikely to survive safely in the community without supervision, based on a clinical determination; (4) the patient has a history of lack of compliance with treatment for mental illness that has either (a) at least twice within the last 36 months been a significant factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition, or (b) 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 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition; (5) the patient is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment pursuant to the treatment plan; (6) in view of the patient’s treatment history and current behavior, the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and (7) it is likely that the patient will benefit from assisted outpatient treatment (see Mental Hygiene Law § 9.60 [c]). The court must also find by clear and convincing evidence that the assisted outpatient treatment sought is the least restrictive treatment appropriate and feasible for the patient (see Mental Hygiene Law § 9.60 [j] [2]).

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,¹ then the physician can seek the patient’s temporary

removal to a hospital for examination to determine whether hospitalization is required (see Mental Hygiene Law § 9.60 [n]).

II.

Respondent contends that the statute violates due process because it does not require a finding of incapacity before a psychiatric patient may be ordered to comply with assisted outpatient treatment. He asks that we read such a requirement into the law in order to preserve its constitutionality.

In *Rivers v Katz* (67 NY2d 485 [1986]), we held that a judicial finding of incapacity to make a reasoned decision as to one's own treatment is required before an involuntarily committed patient may be forcibly medicated with psychotropic drugs against his or her will. Mental Hygiene Law § 9.60, however, neither authorizes forcible medical treatment in the first instance nor permits it as a consequence of noncompliance with court-ordered AOT.²

Nevertheless, respondent urges that, under *Rivers*, a showing of incapacity is required before a psychiatric patient may be ordered by a court to comply with any assisted outpatient treatment. Although respondent — in asking us to read a requirement of incapacity into the statute — disclaims any effort to strike down the law, such a reading would have the effect of eviscerating the legislation, inasmuch as the statute presumes that assisted outpatients are capable of actively participating in the development of their written treatment plans, and specifically requires that they be afforded an opportunity to do so (see Mental Hygiene Law § 9.60 [i] [1]). Indeed, the law makes explicit that “[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 [governing guardianship proceedings] (Mental Hygiene Law § 9.60 [o]).

Respondent concedes that a large number of patients potentially subject to court-ordered assisted outpatient treatment would be ineligible for the program if a finding of incapacity were required. In enacting Kendra's Law, the Legislature determined that certain

patients capable of participating in their own treatment plans could remain safely in the community if released subject to the structure and supervision provided by a court-ordered assisted treatment plan. Such a plan may enable patients who might otherwise require involuntary hospitalization to live and work freely and productively through compliance with necessary treatment.

Since Mental Hygiene Law § 9.60 does not permit forced medical treatment, a showing of incapacity is not required. Rather, if the statute's existing criteria satisfy due process — as in this case we conclude they do — then even psychiatric patients capable of making decisions about their treatment may be constitutionally subject to its mandate.

While “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body” (*Schloendorff v Socy. of New York Hosp.*, 211 NY 125, 129 [1914]) and to “control the course of his medical treatment” (*Matter of Storar v Dillon*, 52 NY2d 363, 376 [1981]), these rights are not absolute. As we made clear in *Rivers*, the fundamental right of mentally ill persons to refuse treatment may have to yield to compelling state interests (67 NY2d at 495). The state “has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill” (*Addington v Texas*, 441 US 418, 426 [1979]). Accordingly, where a patient presents a danger to self or others, the state may be warranted, in the exercise of its police power interest in preventing violence and maintaining order, in mandating treatment over the patient's objection. Additionally, the state may rely on its *parens patriae* power to provide care to its citizens who are unable to care for themselves because of mental illness (see *Rivers*, 67 NY2d at 495).

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 treat-

ment, 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.

Of course, whenever a physician determines that a patient is in need of involuntary commitment — whether such a determination came to be made after an assisted outpatient failed to comply with treatment or was reached in the absence of any AOT order at all — the patient may be hospitalized only if the standards for such commitment contained in the Mental Hygiene Law are satisfied. These standards themselves satisfy due process (see *Project Release v Prevost*, 722 F2d 960 [2d Cir 1983]). If, however, the non-compliant patient is not found to be in need of hospitalization, the inquiry will be at an end and the patient will suffer no adverse consequence. For as the statute explicitly provides, "Failure to comply with an order of assisted outpatient treatment shall not be grounds for involuntary civil commitment or a finding of contempt of court" (Mental Hygiene Law § 9.60 [n]). Moreover, any restriction on an assisted outpatient's liberty interest felt as a result of the legal obligation to comply with an AOT order is far less onerous than the complete deprivation of freedom that might have been necessary if the patient were to be or remain involuntarily committed in lieu of being released on condition of compliance with treatment.

In any event, the assisted outpatient's right to refuse treatment is outweighed by the state's compelling interests in both its police and *parens patriae* powers. Inasmuch as an AOT order requires a specific finding by clear and convincing evidence that the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to self or others, the state's police power justifies the minimal restriction on the right to refuse treatment inherent in an order that the patient comply as directed. Moreover, the state's interest in the exercise of its police power is greater here than in *Rivers*, where the inpatient's confinement in a hospital under close supervision reduced the risk of danger he posed to the community.

In addition, the state's *parens patriae* interest in providing care to its citizens who are unable to care for themselves because of mental illness is properly invoked since an AOT order requires findings that the patient is unlikely to survive safely in the community without supervision; the patient has a history of lack of compliance with treatment that has either necessitated hospitalization or resulted in acts of serious violent behavior or threats of, or attempts at, serious physical harm; the patient is unlikely to voluntarily participate in the recommended treatment plan; the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and it is likely that the patient will benefit from assisted outpatient treatment.

In requiring that these findings be made by clear and convincing evidence and that the assisted outpatient treatment be the least restrictive alternative, the statute's procedure for obtaining an AOT order provides all the process that is constitutionally due.

Nor does Mental Hygiene Law § 9.60 violate equal protection by failing to require a finding of incapacity before a patient can be subjected to an AOT order. Although persons subject to guardianship proceedings and involuntarily committed psychiatric patients must be found incapacitated before they can be forcibly medicated against their will, a court-ordered assisted outpatient treatment plan simply does not authorize forcible medical treatment — nor, of course, could it, absent incapacity. The statute thus in no way treats similarly situated persons differently (see *City of Cleburne v Cleburne Living Ctr., Inc.*, 473 US 432, 439 [1985]).

III.

Respondent next challenges the detention provisions of Kendra's Law, contending that the failure of the statute to provide for notice and a hearing prior to the temporary removal of a noncompliant patient to a hospital violates due process.

Under Mental Hygiene Law § 9.60 (n), when an assisted outpatient who persists in the failure or refusal to comply with court-

ordered treatment may, in the clinical judgment of a physician, be in need of involuntary hospitalization, the physician may seek the removal of the patient to a hospital for an examination to determine whether hospitalization is indeed necessary. If the assisted outpatient refuses to take medication — or refuses to take or fails a blood test, urinalysis, or alcohol or drug test — as required by the court order, the physician may consider this refusal or failure when determining whether such an examination is needed. A noncompliant patient thus removed under Kendra's Law may then be retained in the hospital for observation, care and treatment, and further examination, for up to 72 hours, in order to permit a physician to determine whether the patient has a mental illness and is in need of involuntary hospital care and treatment pursuant to the provisions of the Mental Hygiene Law. A patient who at any time during the 72-hour period is determined not to meet the standards for involuntary admission and retention and does not consent to remain must be immediately released.

When the state seeks to deprive an individual of liberty, it must provide effective procedures to guard against an erroneous deprivation. A determination of the process that is constitutionally due thus requires a weighing of three factors: the private interest affected; the risk of erroneous deprivation through the procedures used and the probable value of other procedural safeguards; and the government's interest (see *Mathews v Eldridge*, 424 US 319, 335 [1976]).

While we disagree with the Appellate Division's determination that the involuntary detention of a psychiatric patient for up to 72 hours does not constitute a substantial deprivation of liberty, we nevertheless conclude that the patient's significant liberty interest is outweighed by the other *Mathews* factors. In the context of the entire statutory scheme, the risk of an erroneous deprivation pending the limited period during which an examination must be undertaken to determine whether a persistently noncompliant patient is in need of involuntary care and treatment is minimal. For before a court order authorizing an AOT plan is issued, there must already have been judicial findings by clear and convincing evidence that the patient is unlikely to survive safely in the

community without supervision; has a history of noncompliance resulting in violence or necessitating hospitalization; and is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm. Nor is a court better situated than a physician to determine whether the grounds for detention — persistent noncompliance and the need for involuntary commitment — have been met. A pre-removal hearing would therefore not reduce the risk of erroneous deprivation.

In addition, the state's interest in immediately removing from the streets noncompliant patients previously found to be, as a result of their noncompliance, at risk of a relapse or deterioration likely to result in serious harm to themselves or others is quite strong. The state has a further interest in warding off the longer periods of hospitalization that, as the Legislature has found, tend to accompany relapse or deterioration. The statute advances this goal by enabling a physician to personally examine the patient at a hospital so as to determine whether the patient, through noncompliance, has created a need for inpatient treatment that the patient cannot himself or herself comprehend. A pre-removal judicial hearing would significantly reduce the speed with which the patient can be evaluated and then receive the care and treatment which physicians have reason to believe that the patient may need. Indeed, absent removal, there is no mechanism by which to force a noncompliant patient to attend a judicial hearing in the first place.

Respondent contends that a comprehensive psychiatric examination can be easily performed in less than 72 hours after removal. But since the temporary detention permitted by the statute comports with due process, it is not for us to determine whether the 72-hour limit is ideal, or necessary, or wise. As long as the time period satisfies constitutional requirements — which it does — it is not for this Court to substitute its judgment for that of the Legislature.

Finally, we find no violation of the constitutional prohibition against unreasonable searches and seizures (see US Const, 4th Amend; NY Const, art I, § 12) in the statute's failure to specify that a physician must have probable

cause or reasonable grounds to believe that a noncompliant assisted outpatient is in need of involuntary hospitalization before he or she may seek the patient's removal. It is readily apparent that the requirement that a determination that a patient may need care and treatment must be reached in the "clinical judgment" of a physician necessarily contemplates that the determination will be based on the physician's reasonable belief that the patient is in need of such care.

Accordingly, the order of the Appellate Division should be affirmed, without costs.

Order affirmed, without costs.
Opinion by Chief Judge Kaye.
Judges George Smith, Ciparick, Rosenblatt,
Graffeo and Read concur. Judge Robert
Smith took no part.

Decided February 17, 2004

Endnotes

- 1 Under Mental Hygiene Law § 9.27, a person may be involuntarily admitted to a hospital upon the certification of two physicians when he or she is in need of involuntary care and treatment, defined as having "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 is unable to understand the need for such care and treatment" (Mental Hygiene Law § 9.01). Under Mental Hygiene Law §§ 9.39 and 9.40, persons in need of immediate observation, care and treatment may be admitted to a hospital on an emergency basis when they have a mental illness which is likely to result in serious harm to themselves or others, defined as a "substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or *** a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm" (Mental Hygiene Law § 9.39 [1], [2]).
- 2 Inasmuch as the statute does not — and could not, absent a showing of incapacity — authorize the forcible administration of psychotropic drugs, any AOT order purporting to contain such a direction would exceed the authority of the law. Respondent's treatment plan contained no such illegal direction. Any persistent refusal to comply with the directive that he voluntarily submit to the administration of Haldol would not have resulted in his being forcibly medicated. Rather, the sole consequence would have been that a physician might then have determined that respondent may have been in need of involuntary hospitalization. In that event, respondent could have been temporarily removed to a hospital for examination (*see* Mental Hygiene Law § 9.60 [n]).