Mayor Adams' Psychiatric Crisis Care Legislative Agenda

NYC

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BACKGROUND:

Involuntary hospitalization and "assisted outpatient treatment" (court-ordered outpatient care, commonly known as "AOT") are essential components of a functional public mental health system. Many people with psychotic disorders experience *anosognosia* (lack of insight), a neurological deficit which can leave them unable to recognize their own mental illness symptoms and need for treatment – no matter how apparent these may be to observers. While voluntary care is always preferable, it is not always a realistic expectation when a person in the throes of psychosis does not believe they are ill and/or has delusions that mental health professionals seek to harm rather than help them.

The New York laws that facilitate treatment in these circumstances have numerous flaws and gaps, adding mightily to the City's challenges in meeting the needs of its most vulnerable residents with severe mental illness. **Mayor Adams' Psychiatric Crisis Care Legislative Agenda** takes aim at 11 legal barriers to psychiatric crisis care and crisis avoidance: five that prevent the timely and effective provision of hospital care, five that prevent the use of AOT with individuals stuck in the mental health system's revolving door, and one that prevents coordination of care between inpatient and outpatient providers when patients shuttle between hospitals and the community.

It must be stressed that the Legislative Agenda is not intended as a cure-all to the full range of challenges facing the City's mental health system. Not all of the conspicuous holes in our safety net lend themselves to legislative patches. Some must be mended through additional investment of resources, solutions to persistent staffing challenges, and other policy reforms.

As the Adams Administration continues to pursue a bold mental health reform agenda, we need our partners in Albany to pitch in with these 11 essential fixes to the state's Mental Hygiene Law. Eliminating the barriers identified below would pay immediate dividends in improved care and would enable our Administration to devote all energies to building a robust network of mental health services and supports to meet all levels of need.

BARRIERS TO HOSPITALIZATION AND CARE COORDINATION:

BARRIER #1: New York's legal standard for involuntary hospitalization (mental illness "likely to result in serious harm" to self or others) is often interpreted too narrowly, denying desperately needed treatment to those who are not demonstrably violent or suicidal or engaging in blatantly dangerous conduct.

When a person is experiencing psychosis and refusing care, the key determination under New York law in assessing their need for involuntary hospitalization is whether their mental illness is *"likely to result in serious harm"* to the person or others. This is the applicable standard in a wide range of circumstances: a mobile crisis outreach team or police officer deciding whether the person should be removed from the community and taken to an ER or CPEP; an ER physician deciding whether the person should be admitted to the hospital's inpatient psych unit; an inpatient psychiatrist deciding whether the person should be held in the unit or discharged; a judge deciding whether the person challenging their inpatient detention should be placed under civil commitment; *et al.*

But the law provides scant guidance as to what constitutes the "serious harm" that must be found likely to result. An all-too-common interpretation is that a person must demonstrate a risk of violence, suicide or grievous bodily harm. This excludes many mentally ill individuals whose risk of "serious harm" is less overt but no less real. More specifically, a narrow interpretation of the "serious harm" standard denies care to:

- Those whose mental illness prevents them from meeting their basic survival needs of food, clothing, shelter or medical care.
- Those unable to recognize their urgent need for treatment, placing them at serious risk of psychiatric deterioration. (Research tells us that in a psychiatric crisis, time is of the essence: *the shorter the duration of untreated psychosis, the greater the person's prospects for recovery.* Some studies have linked extended periods of untreated psychosis to physical brain damage.)

There should be no question that people in these categories – even if not threatening violence or suicide or walking into traffic — are at risk of "serious harm" to themselves, in ways they would surely wish to avoid if their minds were functioning properly. But in New York, such individuals are routinely denied care by evaluators who interpret the law to require a demonstrated risk of violence, suicide or serious bodily injury.

SOLUTION: Add language to the legal definition of "likely to result in serious harm," making it explicit and beyond debate that when untreated mental illness leaves a person unable to meet their basic survival needs and/or helpless to avoid psychiatric deterioration, involuntary hospital care is warranted.

BARRIER #2: Hospital evaluations of whether a person's mental illness remains "likely to result in serious harm" are often based solely on how the individual presents *in that moment*, ignoring the broader context in which their current behavior must be understood and the risks of non-imminent serious harm.

Community outreach teams, shelter staff and families all report as a common frustration that even when they are successful in having a person in psychiatric crisis removed to a hospital, the person is frequently "streeted" within hours or a day or two. This is simply not a long enough period of hospitalization to fully stabilize a person with a psychotic disorder and prepare them to succeed in a community placement. Of course, if the person is unwilling to accept a voluntary admission, hospital staff cannot retain them without finding that their mental illness remains "likely to result in serious harm."

Compounding the problem of an overly narrow interpretation of "serious harm" (discussed above) is the tendency of many inpatient psychiatrists to evaluate the person's condition solely on the basis of how the person presents *at the moment of evaluation*, and to only consider the risk of *imminent harm*. A patient's symptoms may be tenuously controlled by the medication provided in the hospital such that they are no longer exhibiting the alarming behavior that led to their removal and do not appear at risk of causing or suffering harm *imminently*. But this does not mean the person is ready for discharge. A thorough evaluation of their condition must also take account of the available information about their recent behavior in the community, their treatment history, their readiness to adhere to the outpatient treatment they will require to avoid a quick relapse, and the risk that they will inflict serious harm upon themselves gradually over time. Mobile crisis outreach teams and shelter staff, who tend to be much more intimately familiar with the individual than the hospital doctor, are typically eager to share such information for use in evaluation. But too often such information and insight is disregarded in the hospital as irrelevant to the task of evaluating the person under the law.

SOLUTION: Require a clinician evaluating the person's need for hospitalization to take account of all relevant and credible information presented to them, as well as the patient's current ability to adhere to essential outpatient treatment and their risk of suffering harm over time.

BARRIER #3: New York law grants authority to perform a clinical evaluation of a person's need for involuntary hospitalization or AOT *exclusively to physicians* (and in some circumstances specifically to psychiatrists). This prevents the system from making use of other mental health professionals who are equally qualified to perform these evaluations, exacerbates a systemic staffing shortage, and diverts physicians' time from patient care.

There is nothing in the training of physicians to make them uniquely qualified to diagnose mental illness and assess whether such mental illness is likely to result in serious harm. Psychologists, psychiatric nurse practitioners and licensed clinical social workers are all adequately trained to perform this function. (In fact, these professionals are more qualified for this role than physicians who are not psychiatrists.) The same is true for determinations of eligibility for AOT.

All of these professionals are authorized to bill Medicaid and Medicare for diagnosing mental illness and making (non-medical) treatment recommendations. That should be reason enough to acknowledge their qualification to perform evaluations under the Mental Hygiene law.

SOLUTION: Authorize psychologists, psychiatric nurse practitioners, and licensed clinical social workers to evaluate an individual's need for psychiatric hospitalization or AOT.

BARRIER #4: The range of mental health professionals authorized to serve as members of mobile crisis outreach teams is too limited, making these essential teams difficult to staff and reducing the number deployed in the City's streets and subways.

The City urgently needs more mobile crisis outreach teams (MCOTs) to identify individuals in the community with acute mental health needs, engage them in voluntary treatment when possible, and direct their removal to a hospital for evaluation when necessary. The challenge of meeting this demand would be greatly reduced if MCOTs could be assembled from a wider pool of mental health professionals than current law allows. Licensed mental health counselors and licensed marriage and family therapists are fully capable of doing this work, but are not included in the current law's definition of "qualified mental health professional," leaving them ineligible to receive MCOT training.

SOLUTION: Expand the range of potential MCOT members to include licensed mental health counselors and licensed marriage and family therapists.

BARRIER #5: New York law does not authorize a mental health professional working in a homeless shelter to direct the removal of a client in psychiatric crisis to a hospital.

Mental health professionals working in homeless shelters frequently encounter clients in psychiatric crisis in need of removal to a hospital. Under current law, shelter staff lack authority to direct removals, leaving them dependent upon police to exercise their own removal authority. Often, the opinion of the police officer who arrives on the scene does not align with the training-informed judgment of the shelter staff member who requested the assistance, leaving the shelter unable to effectuate the removal.

SOLUTION: Authorize shelters and other adult care facilities to direct hospital removal of a resident in psychiatric crisis, based upon the judgment of a mental health professional on staff.

BARRIER #6: New York law requires no communication or coordination of care between inpatient and outpatient providers, causing patients to lose critical connections upon moving between inpatient and outpatient treatment settings.

Community providers serving clients with severe mental illness, such as ACT and IMT teams, face an immense challenge in keeping track of their clients' whereabouts and condition, especially with those who are homeless. This often becomes an impossibility when a client experiences a crisis event and is hospitalized. Current law imposes no duty on hospitals to inform outpatient providers when their clients are admitted or discharged, even when a patient's connection to an outpatient provider is readily available information in PSYCKES, the electronic database shared across the state system. Nor are hospitals required to involve the patient's community-based providers in discharge planning.

Outpatient providers are frequently left to wait helplessly for their clients to re-appear on the scene. Sometimes the person is discharged to a different area of the city and connected to a new outpatient provider, forfeiting the therapeutic value of bonds forged with the former provider.

This is not how a mental health system should function. Coordination of handoffs between inpatient and outpatient providers is one of the primary purposes of the PSYCKES system, but has failed to take hold as standard practice.

SOLUTION: Require hospitals to make reasonable efforts to identify their psychiatric patients' community providers (i.e., check PSYCKES), inform providers of admission decisions and discharges, and consult providers in the development of discharge plans.

BARRIERS TO AOT:

BARRIER #7: Screening of psychiatric hospital patients for AOT eligibility has been inconsistent, leading to missed opportunities to utilize AOT in transitioning at-risk patients back to the community.

The lifeblood of any AOT program is the flow of individuals coming directly off psychiatric hospitalizations who have been flagged as "revolving door" patients based on multiple recent hospitalizations resulting from difficulties adhering to outpatient treatment. When utilized, AOT has been remarkably successful in helping this population remain in the community and avoid repeat hospitalization and arrest. But there is good reason to wonder whether the City's AOT program is connecting with the full cohort of individuals leaving hospitals who meet the legal criteria. The program currently depends on hospitals to make AOT referrals based on their own screening procedures. There has been wide variance among City hospitals, both inside and outside the H+H system, in the frequency that such referrals are made, raising concern that a significant number of AOT-eligible patients are being missed.

SOLUTION: Make AOT-eligibility screening of psychiatric inpatients a standardized discharge planning practice for hospitals. Require submission to the NYS Office of Mental Health a report on the findings and actions taken on each AOT review.

BARRIER #8: A New York Court of Appeals decision (Miguel M.) requires DOHMH to obtain a person's consent before accessing the medical records it needs to establish AOT eligibility. Individuals who don't want to participate in AOT often withhold consent, making it impossible to collect the necessary evidence to support an AOT petition.

While it is certainly preferable and common for a person to enter the City's AOT program willingly, AOT is an involuntary intervention by design. This is necessary because many of the individuals it seeks to help lack insight (awareness of their own mental illness and need for treatment). If AOT operates as a voluntary program, it forfeits much of its potential to achieve breakthroughs with treatment-resistant patients by helping them over time to recognize the benefits of treatment engagement.

Regrettably, the New York Court of Appeals' 2011 decision in the Miguel M. case has effectively turned AOT into a voluntary program at the initial stage. The court ruled that when the City is conducting an AOT investigation pursuant to a referral, federal law ("the HIPAA Privacy Rule") does not allow the City to obtain hospital records without the patient's consent. In other words, a person who isn't interested in participating in AOT can simply withhold consent to release of their records and prevent the City from obtaining the evidence it needs to establish that they meet AOT criteria.

For patients coming into AOT directly from hospitals, this usually doesn't present a problem. These patients typically consent to record disclosure because they perceive that AOT will lead to an earlier hospital release. But the Miguel M. ruling has wreaked havoc on to the City's ability to investigate AOT referrals for individuals currently residing in the community, including many referrals made just prior to a person's release from Rikers Island. In such cases, the person who doesn't welcome AOT has no incentive to consent to record disclosure. These referrals typically go nowhere.

A solution to this quandary lies in a federal regulation providing an exception to the HIPAA Privacy Rule for disclosures made pursuant to judicial proceedings, so long as the patient receives adequate advance notice of the disclosure request and a fair opportunity to challenge the disclosure in court. This exception was not considered by the court in Miguel M. because New York's AOT law does not include such due process prior to a disclosure of hospital records.

SOLUTION: Require hospitals to share treatment records with City health officials conducting an AOT investigation, but only after the patient has been afforded a reasonable opportunity to challenge the disclosure in court.

BARRIER #9: Although DOHMH routinely seeks AOT court orders for a term of one year as the law allows, many judges prefer to impose shorter terms. This defies research showing that shorter periods of AOT are less effective in helping patients develop sustainable habits of treatment engagement.

The original Kendra's Law in 1999 limited the maximum term of an AOT order to six months. In the New York SAFE Act of 2013, the potential order length was increased to one year, in recognition of a striking research finding that a year after graduation from the program, patients who had spent longer than six months under AOT (through renewed court orders) had generally remained successful in avoiding hospitalization and arrest, *even if they had not continued under intensive case management*, while those who had spent six months or less under AOT needed continued intensive case management to avoid regression. The legislative intent behind the 2013 amendment was to make one year the "default setting" for a period of AOT. It is therefore troubling that some judges have shown a consistent preference for shorter AOT periods, defying DOHMH's standard requests for year-long court orders.

SOLUTION: Amend language on the length of an AOT order, from "*not to exceed* one year" to one year by default, provided that the court may shorten the order period upon a showing of good cause or the petitioner's request.

BARRIER #10: Hospital psychiatrists are disincentivized from filing AOT petitions by the burden of having to take time away from their hospital duties to testify in person at court hearings.

One of the major disincentives for hospital psychiatrists to seek AOT for their discharged patients is the burden an AOT petition places upon the psychiatrist to take time away from their hospital duties and spend at least a half-day (unbillable) traveling to court, waiting for the case to called, and providing a few minutes of testimony at the hearing. Advances in technology since the enactment of Kendra's Law should obviate the need for a clinician to make this commitment of time and effort.

Under a 2022 amendment to the AOT statute, the court is authorized to permit video testimony upon a finding of the psychiatrist's diligent efforts to appear in person or for good cause shown. But these options do not advance the goal of encouraging AOT referrals from doctors who would rather *not* make "diligent efforts" to appear and who could not be confident in advance that the court would find "good cause" for video testimony.

While some maintain that the Sixth Amendment establishes a respondent's right to have adverse testimony presented in person, this should be not be a concern if the potential AOT patient consents to remote testimony. Most AOT petitions are uncontested, so it is reasonable to assume that many patients would willingly waive this right. Establishing this as an option would encourage AOT referrals when a hospital psychiatrist has discussed AOT with their patient and knows that the patient is willing to participate in the program and will not contest the petition.

SOLUTION: Amend the AOT law to allow clinical testimony by video link in any case where the respondent is willing to waive their right to live testimony.

BARRIER #11: The provision of the AOT law allowing recent graduates to return to the program upon signs of regression is difficult to utilize.

A 2022 amendment established a new procedure to obtain an AOT order for a person who was discharged from AOT within the last six months and appears to be regressing. Such person may no longer qualify for AOT under the standard eligibility criteria, if they have not been newly hospitalized, arrested or violent, and the previous such incidents which qualified them for AOT previously are now too far in the past to satisfy the statute. But ambiguity and complexity in the new language make it difficult for the City to make use of the new "return-to-AOT" option, and to date no such petitions have been attempted.

SOLUTION: Simplify the path for a recent AOT graduate to return to the program. Allow such a return upon a showing of a substantial increase in mental illness symptoms which interferes with the person's ability to maintain their health or safety.