

Assisted Outpatient Treatment Through Kendra's Law



A NAMI New York State White Paper



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Executive Summary

The National Alliance for the Mentally Ill - New York State represents 58 affiliate organizations with more than 5,000 members throughout New York State. The majority of its members belong to families with loved ones who have a mental illness, including loved ones who are being served by Assisted Outpatient Treatment (AOT) through Kendra's Law, which will "sunset" on June 30, 2005. This report discusses our members' experiences with AOT.

Sources of this report include interviews with 20 families with loved ones on court-ordered AOT. To maintain their confidentiality, family members are identified by a fictitious first name and the (real) region they are from. Sources of this report also include interviews with 41 NAMI-NYS affiliate leaders, several AOT providers and a meeting with the Director of Assisted Outpatient Treatment for the New York State Office of Mental Health.

Kendra's Law, which went into effect in November 1999, is named for Kendra Webdale, who was pushed in front of a subway train by a man with severe schizophrenia who was off his medications. It provides for civil courts to order treatment plans for individuals that meet a number of criteria. They must not be likely to survive safely in the community without supervision, have a history of lack of compliance with treatment that includes hospitalizations and/or has resulted in acts of serious violent behavior, are not likely to voluntarily participate in recommended treatment, need assisted outpatient treatment and are likely to benefit from such treatment.

An AOT order comes after a hearing in which a court finds — by clear and convincing evidence garnered from a pre-hearing investigation — that the person not only meets those criteria, but the treatment the order calls for is the least restrictive available alternative. The treatment plan is agreed upon with the person before it is ordered, and it lays out the services he or she is to receive. These can include medication; 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, counseling and testing; supervision of living arrangements, and other services, such as housing, he or she may need. The common denominator of all treatment plans is the appointment of a case manager to assist the person in following the plan.

Our research found that such Assisted Outpatient Treatment has a positive impact, not only on the lives of those who are "on AOT," but also on the mental health system. AOT works and can work well when properly implemented, not only saving lives but giving individuals much brighter futures. For these reasons, we urge the state to enact a new Kendra's Law and make it permanent.

However, our research also found in several cases that the services provided under AOT could have been much better. Whether one receives quality AOT services, or any AOT services, depends upon where one lives and whether local mental health providers take the law seriously. A new Kendra's Law must provide for more accountability from those who are responsible for carrying it out. The Office for Mental Health must be given the responsibility, on a case-by-case basis, to ensure that localities act if they decline or fail to investigate potential AOT cases, to submit a petition for a hearing, to provide services called for by the treatment plan or to correct service deficiencies. Some basic standards need to be adopted, especially the completion of AOT investigations within 30 days. The funding formula for localities needs to be changed to provide an incentive for providing AOT; currently there isn't any.

In order to provide more accountability, families, who are their loved ones' front line caregivers and advocates, must also be empowered. The current Kendra's Law permits them to file a petition for an AOT hearing but makes it virtually impossible for them to accomplish this. Families also need the means to obtain redress from OMH regional AOT Program Coordinators if localities do the wrong thing in terms of declining or failing to investigate potential AOT cases, to submit

petitions, to provide services or to correct service deficiencies.

The new Kendra's Law also needs to make the initial AOT period a year, urge the education of judges on the law, provide for the transfer of treatment plans from county to county, provide for voluntary agreements and settlement agreements as a way to deliver AOT without going to court, and provide for the consideration of a higher level of care if an individual meets all the other criteria for AOT but is not likely to benefit from it.

In short, Kendra's Law must be made permanent but must also be improved to be more effective.

The Purpose of Kendra's Law

According to an article in our most recent newsletter by NAMI-NYS board member Pat Webdale, whose daughter Kendra is for whom the law is named, Kendra's Law is intended to help those who need it to stay on the road to recovery. Just as some people need glasses to maintain control of their vehicles, some need ongoing treatment to maintain control of their own lives.

Those who need Assisted Outpatient Treatment are without exception severely ill individuals, afflicted with diseases that are not only debilitating but deadly. Research has shown that more than 90 percent of those who complete suicide have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders. Those who are now being served by Kendra's Law are among those who are most apt to complete suicide, and, occasionally, their illnesses can be deadly to others. Also, they are among those in our community who are most vulnerable to abuse, and even murder, especially if they are homeless.

Mental illnesses are medical diseases of the brain. They are often very treatable, more so than many physical illnesses. According to the National Advisory Mental Health Council, the success rate for treatment of a first episode of schizophrenia is about 60 percent, and the treatment success rate for major depression and bipolar disorder is about 80 percent.

At his trial, Andrew Goldstein, the man with severe schizophrenia who pushed Kendra Webdale in front of a subway train, said, "[I]f I had taken my medication that whole thing would have never happened."

Symptoms of severe mental illness include hallucinations, delusions, extreme moods and a phenomenon called anosognosia or "lack of insight," a lack of awareness that the person is ill. To varying degrees, about half of those with schizophrenia and 40 percent of those with bipolar disorder simply don't understand they have an illness. Two things often happen as a result: 1) Individuals in this situation perceive their hallucinations and delusions as real, and 2) they do not show up for treatment. Why would anyone want to be treated for an illness one doesn't have?

In such cases, decompensation usually follows, whereby the individual can end up either in the hospital, on the street, in jail or in the morgue, depending upon luck and what "supports" he or she has, the most effective of which is a caring family.

Mental illness attacks the brain and affects the mind. Indeed it can take control. Medical treatment is needed for the individual to regain control. In severe cases, such treatment requires hospitalization and then ongoing outpatient treatment in order for the person to maintain control, to survive safely in his or her community and to begin the process of recovery. In some of these cases, in which Anosognosia is often a major factor, the person is not only so sick that he or she needs assistance in obtaining ongoing outpatient treatment, but also is a risk to self or others without such treatment. It is to help these persons that Assisted Outpatient Treatment was created through Kendra's Law.

Assisted Outpatient Treatment Works

We found overwhelming evidence that, when properly implemented, Assisted Outpatient Treatment has an exceedingly beneficial impact, both on those it serves and on the mental health care system itself.

A question we asked many of the families we talked to was, "If you had to do it all over again, would you pursue the AOT process?" Most of them unequivocally said they would, even though the AOT process is very difficult, and, according to several families, asking for AOT for their loved ones was among the most difficult decisions they've ever had to make.

"It's our first glimmer of real hope in 14 long and destructive and DANGEROUS years of illness," said "Jennifer" from Long Island. During those years she was homeless at times, raped, beaten and contracted several non-curable sexually transmitted diseases. AOT should not be interpreted as impinging on the rights of the individual but rather enforcing the right of the individual to be treated for potentially life-threatening disease."

"Without AOT, my son would either be in jail or dead," said "Susan" from New York City. "It alone has made a difference for him by helping him to stay on his meds. It is an important safeguard for people with severe mental illness."

"It's the only way to keep people in treatment who don't see they need it," said "Gwen" from Western New York.

"AOT has been a Godsend," said "Sylvia" from Central New York. "It has given my brother such a better quality of life. Before, it was a nightmare. AOT has worked wonderfully."

"It's been a lifesaver," said "Bill" from Long Island. "Since my son is in AOT, life has improved for him and thus the entire family."

"It protects both the patients and the public and saves taxpayer money by cutting down on hospitalizations," said "Marla" from Long Island.

According to the state Office of Mental Health's interim report on Kendra's Law — which combined statewide statistical reports with in-depth studies of eight geographically representative counties and New York City — 70 percent of those receiving an AOT court order have a diagnosis of schizophrenia, 13 percent have a diagnosis of bipolar disorder and 60 percent are reported as having a co-occurring mental illness and substance abuse condition with mental illness as the primary diagnosis. When compared with a similar population of mental health service recipients, persons under AOT were twice as likely to have had contact with the criminal justice system and 50 percent more likely to have had a previous episode of homelessness.

According to the interim report, after six months of AOT, the incidence of "significant events" in the lives of individuals in the program dropped considerably from their pre-AOT levels. For all AOT recipients, the incidence of psychiatric hospitalization dropped from 87 percent to 20 percent, the incidence of homelessness dropped from 21 percent to 3 percent, the incidence of arrests dropped from 30 percent to 5 percent, and the incidence of incarceration dropped from 21 percent to 3 percent.

Those exhibiting "poor engagement of services" went from 59 percent to 34 percent, and those exhibiting "poor medication adherence" dropped from 67 percent to 22 percent after six months.

Recipients also showed improved functioning in the areas of self-care, community living, interpersonal functioning and task performance. There were also statistically significant reductions in harmful behaviors such as substance abuse, suicide attempts and phys-

ical harm to self.

These results are consistent with the findings of studies on Assisted Outpatient Treatment in other states. For example, a North Carolina study found that for individuals who had a history of multiple hospital admissions combined with arrest and/or violence in the prior year, long-term AOT reduced the risk of arrest by 74 percent. This study also showed that North Carolina's program reduced hospital admissions by 72 percent and length of hospital stay by 28 days for individuals with schizophrenia and other psychotic disorders compared to such individuals without AOT.

In Ohio, outpatient commitment increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13 per year and with attendance at day treatment sessions from 23 to 60 per year. In Arizona, among patients who had been outpatient committed, 71 percent of the patients voluntarily maintained treatment contacts six months after their orders expired, compared to almost no patients who had not been put on outpatient commitment.

Why AOT Works as Well as It Does

Several families we talked to said a reason why AOT was effective in their case is because it had persuaded their loved ones to agree to treatment when all else had failed — even though their loved ones often felt a great deal of anger and resentment about being taken to court. It is the nature of our society that people who will not listen to anybody else will often listen to a judge.

Whether or not the process greatly upset them, and it did in many cases, it gave these individuals their day in court, which the great majority of them took very seriously. "Sylvia" from Central New York said the court procedure "justified" treatment in the mind of her brother, upholding the part of him that knows he needs help.

"It provides the leverage that makes a difference," said "Susan" from New York City.

"Donald," from Long Island said before AOT, which is a civil procedure, his son had wound up in criminal court. "In civil court, they treat you like a human being," he said. "In criminal court, it's really that you're guilty until proven innocent. They treat you like an animal."

Donald said without AOT he had no doubt his son would wind up in criminal court again, so whether to continue Kendra's Law really is a question of whether his son's illness should be treated as a criminal or a civil matter.

Another reason why families said that AOT had worked is that it not only provides leverage with their loved ones but also with the system that serves them. This is the other side of the care equation: There must be cooperation not only from the consumer, but from the provider as well. Indications are that most mental health care providers are taking AOT seriously and often give those who are on AOT priority in receiving services.

In Donald's son's case, for example, AOT provided a treatment plan with clear directions that the police were to take him to a specific hospital when he went into crisis. He said this was important because, "when police come over, they like to take people to jail."

Equally important to an effective treatment plan, Donald said, was that AOT provided an Assertive Community Treatment (ACT) team to carry the treatment plan out and also gave his son top priority for very scarce community mental health housing.

"Bill" from Long Island said because his son is on AOT, he has been kept in a hospital for over a year, and is going to be discharged to a group home. Before AOT, he was discharged from "every hospital imaginable" after only a brief stay, often without medica-

tions or an outpatient treatment plan.

"I feel it is very important for my son to be on AOT because it makes providers take him more seriously and makes them do their job better," said Bill. "A person on AOT is mandated to get the services he needs."

To understand the tremendous shift in priorities this represents, and the significance of AOT's impact on the state's mental health care system, one has to understand the way things were before AOT: If a person was "noncompliant" — if the person didn't show up at an outpatient clinic, for example — his or her case was often simply closed, and no further action was taken. Agencies also cherry-picked the less difficult cases for their programs. This, literally, left the most seriously mentally ill out in the cold and resulted in many preventable tragedies.

AOT has made a critically important contribution to mental health care by making the system more responsible for the most serious cases in the community. Providers can no longer allow people to "fall through the cracks" with impunity. As Pat Webdale's article puts it, the only right the law has infringed is "the right to do nothing, even in the direst circumstances."

In this regard alone, Kendra's Law is landmark legislation, with a potential impact on mental health care as significant as deinstitutionalization and reinvestment.

According to OMH's interim report, local mental health systems have gone through important changes as a result of AOT, and the benefits include enhanced accountability, improved access to services, improved treatment plan development and discharge planning, improved coordination of service planning and improved collaboration between the mental health and court systems.

Here is what the report says on accountability (page 5):

AOT has increased accountability at all levels regarding delivery of services to individuals who have high needs or who are at high risk to themselves or others. Community awareness of AOT has resulted in increased outreach to individuals who were previously difficult to engage (or had difficulty becoming engaged) in mental health services. By alerting local mental health systems to the potential risk posed by not responding to an individual's situation, those systems improved their ability to mobilize around the needs of these individuals.

The increased accountability did not occur in a vacuum. In order to ensure that persons with serious mental illness will not continue to fall through the cracks, the state made the single largest investment in mental health services in its history. In fiscal year 2000-2001, the state budgeted \$32 million to enable localities to provide AOT, although it is difficult to determine how much of that money has gone toward actual AOT services (this issue will be addressed in a later section). The 2000-2001 budget also included \$125 million in new money for a range of services to help persons with serious mental illness, including those, such as children, who do not qualify for AOT. It funded an expansion of case management, housing and community services, including a major expansion of Assertive Community Treatment teams (from a handful to about 70). It created a Single Point of Access system for case management and housing, where the AOT population and other difficult cases, such as those who are homeless or were incarcerated, are given top priority. It also created a system through which persons with serious mental illness who have been released from jail and do not yet qualify for Medicaid can get their medications.

Thanks to the efforts of the Office of Mental Health, the State of New York and various localities, it has been shown that AOT can work, and work well when properly implemented. AOT provides a level of care that was missing before Kendra's Law was enacted and has made a major difference for the better in many people's lives. It has also improved local mental health systems to an extent that was largely unanticipated. For

these reasons, NAMI-NYS wholeheartedly supports passage of a new Kendra's Law that would be permanent.

Why AOT Does Not Work as Well as It Should

For too many people in New York State, AOT still hasn't worked yet as it should. While the statistics on AOT indicate real trends, the actual results according to our families are more mixed than what the numbers seem to show. Even several of the families who said they would pursue AOT all over again said so because they believe it is their only option, and it is "better than nothing," but it has fallen short of their expectations.

Again, the Office of Mental Health and New York State should be congratulated for their accomplishments in establishing AOT. Because of their efforts, and those of localities that saw its value, there are several excellent AOT programs around the state. We understand AOT programs in Brooklyn, Staten Island and Ulster County are in this category.

But there are other programs that, for one reason or another, are not delivering services they way they should. A major reason for this is there simply aren't enough services and/or resources for persons with serious mental illness. Community mental health services are struggling financially, and in many cases AOT is being provided by understaffed organizations with personnel who are poorly trained, poorly paid and inadequate to the task. The result is that while treatment plans may look good "on paper," they too often do little to help the person other than encouraging medication compliance.

"From the point of view that he's still alive and not wandering around, it's been good," "Wendy" from Central New York said. "I just wish there was something more substantial in our area. It's the quality of services that is a problem. They're not helping him to recover."

When services and basic resources are lacking, AOT cannot be effective. Housing is a basic resource, and the lack of mental health housing in New York City has created a major problem for its AOT case managers.

Despite the influx of money for case management and other services precipitated by Kendra's Law, AOT would benefit from better services and resources in many counties throughout the state. A lack of services and resources is a factor in virtually all of the other reasons why the implementation of AOT is not as effective as it should be.

The other major factor has to do with the shift in mindset that Kendra's Law demands. Historically, providers have focused on helping those with insight and a desire to recover, for whom it is naturally much easier to provide care and promote recovery. The subtext of Kendra's Law is the struggle to shift providers' focus to the people who need the most care in the community, those who need coordinated services through Assisted Outpatient Treatment. While a good beginning has been made, the struggle is far from over. Although AOT has promoted systemic accountability, many providers still aren't accountable enough when it comes to Kendra's Law in particular. Changes must be made to provide more accountability.

Getting to AOT

The problem with Kendra's Law that was most identified by our members is that many counties are either not implementing the law or implementing it poorly. Despite efforts to implement a statewide system, a determining factor in whether one receives AOT is where one lives. According to the Office of Mental Health's statewide AOT report for the period ending May 1, 2004, counties vary considerably in their implementation of Kendra's Law. Allegany and Cattaraugus counties, for example, are next to each other and have similar populations, but Cattaraugus County has conducted 65 AOT investigations, since

the law went into effect in November 1999, and Allegany, only 17. As far as we know, Ontario and Chenango counties have not conducted even a single investigation. Several other counties have conducted only one investigation.

The reasons for simply not implementing AOT are many. The process is expensive and time-consuming. Resources are scarce. Some Directors of Community Services are philosophically opposed to it, not wanting to "upset the provider-consumer" relationship, even though no such relationship exists for many of those who need AOT. When discussing these reasons with our members, several of them were adamant that they should not stand in the way of compliance with the law. As one put it, "Is this a law or a set of recommendations?"

The consequences of this state of affairs are predictable.

A family in Chautauqua County tried for five months to obtain AOT for a loved one who was throwing rocks at cars, running people off the road, harassing local politicians and making agonized calls to 911. Only after their loved one had set fire to his home and attempted to hold the firemen and police off with a shotgun did they get an answer from the county that it had judged he did not meet the criteria for Kendra's Law, the reasons for which were confidential.

Asked what recourse a family has if it wants to petition for AOT and the county does nothing, an OMH official said it is the responsibility of the counties to investigate and resolve whether their loved ones qualify, and then get back to the families. If a family feels a county has turned them down even though their loved one would qualify, they should call the OMH regional coordinator, who should work with the county to take a second look at the case. The official also said a lot is based on clinical judgment, which is subjective. The official said this gives the law flexibility, but it also means that one county might disqualify someone when another county wouldn't.

Clearly, in such cases, the law does not provide for enough accountability, nor does it provide for a means to correct mishandling. Upon the request of a person who requested an AOT petition, OMH Program Coordinators should review any request on which a county declines or fails to act, including any pre-hearing investigation, or lack thereof, connected to the request. On finding that a county's AOT investigation was inadequate, a Program Coordinator should be empowered to instruct that a sufficiently comprehensive one be conducted. Should the coordinator determine that the subject person likely meets the eligibility criteria for AOT, the coordinator should direct the county to petition for AOT.

Families as Petitioners

Strengthening the hand of OMH to enforce the law is essential, but that alone will probably not be enough to significantly increase the odds of provider accountability. The role families play in looking out for the best interests of their loved ones is critical to successful treatment, especially with those who are so ill as to be served by AOT.

More than anyone, families make the system accountable because of their direct stake in the outcomes that services are supposed to achieve. We believe the drafters of the current Kendra's Law had this in mind when they wrote the clause permitting families to be AOT petitioners.

Had the family in Chautauqua County petitioned directly to a court for their loved one, the court may have decided that he did indeed qualify for AOT. But, although the law permits families to file AOT petitions with courts directly, it requires them to follow the exact same process as if they were counties and hospitals. This is like permitting them to climb Mount Everest. If a family has the financial wherewithal to hire the attorney to draw up the petition and hire a physician to do the evaluation, it will rarely have the means, including

all the signed releases, to gain access to required medical records. In general, unless they are hospitals, those who are authorized by Kendra's Law to be petitioners are, in all practicality, dependent upon their counties to conduct an investigation.

Onerous as it is for families to meet the investigative requirements, there is another hurdle that makes the petitioning process virtually impossible for them: The law also requires the petitioner to present a treatment plan, something that is in the purview of qualified mental health care providers, not families.

According to the Office of Mental Health, since the law went into effect in November 1999, there have been only two direct family petitions.

To make the family petition option meaningful and to hold providers accountable, we ask that a new Kendra's Law include the following:

If a person authorized to petition the court directly for assisted outpatient treatment requests a Local Governmental Unit to conduct an AOT investigation, and the LGU has either refused or failed to conduct such an investigation, the authorized petitioner may file a petition with the court 30 days after such request, with evidence supporting that the person is likely to qualify for AOT. If a judge finds there is reasonable evidence to believe the person would qualify for AOT, he may order the LGU to provide medical records to an independent physician selected by the family or assigned by the court. The physician shall evaluate the records and the person, if feasible, for a determination as whether the person does qualify for AOT.

If the court later finds that the person may qualify for AOT based on the independent physician's evaluation, it could then allow the records to be used by the petitioner and schedule a hearing as well as have the Local Governmental Unit prepare a treatment plan, i.e., start the normal process of private petitioning. The LGU should pay all costs accrued by the petitioner in petitioning the court, including attorney's fees and physician's costs.

Following is a complimentary process that provides court oversight when a LGU either fails to properly investigate a report that someone is eligible for AOT or declines to initiate AOT when an individual meets the AOT standard. We recommend it also be included in the law:

If a person authorized to petition the court directly for assisted outpatient treatment requests a Local Governmental Unit to conduct an AOT investigation, and the LGU has either refused or failed to conduct such an investigation, the authorized petitioner may file a petition with the court 30 days after such request, with evidence supporting that the person is likely to qualify for AOT. If a judge finds there is reasonable evidence to believe the person would qualify for AOT, he may order the LGU to either establish that it, with due diligence, performed an appropriate investigation or to conduct one. Should the court order an investigation, the LGU shall pay all costs accrued by the petitioner in petitioning the court, including attorney's fees and physician's costs.

Asked what makes a county not want to conduct an investigation, OMH's response indicated that one problem is a misplaced fear of liability, even though counties could be more liable if they don't enforce AOT.

Too often, counties abide by the rule of, "when in any doubt at all, do nothing." Providing that families may file with a court enough evidence to conclude that an individual would qualify for AOT if a proper investigation were conducted would ensure appropriate action in such cases. Providing that the LGU shall pay the family's court costs if the individual does indeed qualify for AOT would also help to insure appropriate action.

Families have often waited six or more months for investigations to be conducted. **By then the individuals in question can be in a very bad way. Five months after they had requested an investigation, the family from Chautauqua County was still waiting for an answer on whether their loved one qualified for AOT, and it took a standoff with police and**

firemen to bring the matter to a head.

It should be mandatory that investigations be concluded within 30 days, unless there are documented extenuating circumstances. It should be mandatory that, 30 days after receiving a request for an investigation, county AOT program directors report the outcome of the investigation to the persons who made the request and to the OMH Program Coordinators responsible for their counties. This report should state the county's determination as to whether the subject individual would qualify for AOT. If the county determines an individual does not qualify for AOT, it should be mandatory that the county tells the person who requested the investigation which criterion or criteria the individual failed to meet. If the county has failed to conduct or conclude the investigation, it should say so and state why.

Education of Judges

Besides the dubious application of the law by many counties, a common frustration voiced by our sources was that many judges who are conducting AOT hearings don't really understand what the law is about. This is why a model Assisted Outpatient Treatment law created by the Treatment Advocacy Center, a national public interest group, calls for a tribunal consisting of a lawyer, a clinician and a consumer or family member to hold AOT hearings, instead of civil court judges. Such a tribunal would have the expertise to make an educated decision on such cases. There is a difference between the clinical and criminal definitions of "dangerousness," for example, and such a tribunal would use the clinical definition, which is the appropriate one.

We do not advocate for the establishment of such tribunals in New York State, however, because we believe that the established precedents of the civil courts offer the best safeguards to individual rights. For centuries, civil courts have been judging on how the law should be applied on a case-by-case basis, which is the best protection of individuals who have illnesses that in each case exhibit in a different manner and personal situations that also vary from case-to-case.

This is new ground for the civil court system, however, and many judges, in both civil and criminal courts, simply do not understand the basics of mental illness — what it is and what it is not — as well as specifically how to apply Kendra's Law.

According to the Office of Mental Health, it would welcome opportunities to train judges in these subjects.

In New York State, determining what training is needed for judges is in the purview of the New York State Court of Appeals. Recognizing this, we do not ask the legislature to legislate the training of judges. We do ask, however, that a statement to the effect that local courts shall designate specific judges in their jurisdiction to hear Kendra's Law cases be included in the new Kendra's Law, and the following be included in the legislative Message of Intent attached to it:

The Legislature urges the New York State Court of Appeals to set appropriate standards of education about serious mental illness and Kendra's Law for judges designated by localities to hear Kendra's Law cases.

Transfer of Plans from County to County

Gaps in the system have been revealed when individuals who are on AOT have moved from one county to another. Because their court orders don't follow them, very ill individuals are simply "crossing the border" to other counties to avoid treatment, not only thwarting the law but putting themselves and their new communities at risk. The Office of

Mental Health has told us it has been working on this problem, and it is less of a problem then it has been.

We believe that a formal procedure should be set up, however, whereas the AOT director of one county can transfer an AOT order, with treatment plan, to his or her counterpart in another county to which a person on AOT has relocated. The AOT director to whom the order is transferred should be required to file the order, with any suggested changes in the treatment plan, with his or her county's civil court within five days. The court should then have three days to review the order without a hearing, accept or reject any or all of the proposed modifications to the treatment plan, and then make the provision of services pursuant to the order binding on that county's AOT program. On receipt of the original order and until the new court issues an updated one, the AOT director in the new county should be required to supply the services in the incorporated treatment plan to the extent they are available in that county.

Enhanced Services/Voluntary Agreements

Many times after someone qualifies for AOT, his or her case never reaches the hearing stage. Instead, he or she is offered what is called "enhanced services" upstate and a "voluntary agreement" downstate. This is an ad hoc agreement made with individuals in lieu of going to court. Under the threat of being brought to court, they agree to take their medications or participate in other treatment services.

This alternative to going through the court process can work very well. Sometimes the threat of Kendra's Law is enough to persuade individuals to maintain their treatment. They can also save localities time, money and effort.

OMH acknowledges enhanced services or voluntary agreements as a part of the process. In its document, "AOT Procedural Questions about Investigation Process," it states, *The decision to pursue an AOT order is a clinical determination and AOT must be considered to be the least restrictive alternative. If an individual meets most of the AOT eligibility criteria, but for example, has never received case management or ACT services, an enhanced service package could be considered. This would involve the assignment of a new case management service, or more intensive case management service...*

A signed voluntary agreement is not mandatory. However, the cooperation of the recipient with the treatment plan is vital for enhanced services to be effective. There should be a mechanism in place for these individuals to be monitored in a similar manner to that of AOT cases.

While OMH states there should be a monitoring mechanism in place, OMH itself does not take responsibility for such monitoring, although it does keep statistics on the number of enhanced services being provided on a county-by-county basis. According to OMH, they are not privy to service enhancements or voluntary agreements as they are not in the statute.

Because the current law has never provided for them, not only are these agreements not in the purview of OMH, but there is no real definition of what they are and what minimum standards they should meet — whether they should include a treatment plan, for example, or need to be signed by the individual.

And they are unenforceable. They offer the maximum in flexibility and the minimum of accountability. Again, this is not necessarily bad if they work but raises problems if they don't. It's possible to be "least restrictive" to a fault.

According to OMH's report of last May, New York City accounted for 2,509 AOT court orders and only 748 service enhancements, while the rest of the state accounted for 1,705 service enhancements and only 715 court orders.

According to our sources, the reason for the inverse ratio of court orders to service enhancements between New York City and the rest of the state is the nature of New York City. It is a city of mobile strangers where there is greater opportunity to break agreements and get away with it. Something more than a handshake is needed, and a "better safe than sorry," attitude has been adopted.

Along with obtaining more than three times as many court orders than the rest of the state, the city's AOT coordinators are apt to use service enhancements, in the form of voluntary agreements, as step-down arrangements for people coming off of court-ordered AOT. They have also tried to formalize voluntary agreements by making contracts for individuals to sign.

We urge the state to at the very least review such contracts and give them standing in the law, so they can be recognized as legal and come within the purview of OMH. We also urge the state to set standards for them: that they be signed, include a treatment plan (including case management), and, if they are broken, that the signer will be subject to the AOT court process. We believe the city might use voluntary agreements more if this were accomplished.

The advantage of formalizing the enhancements is that the types of services required and the use of a written agreement (currently non-binding) can be mandated. Also, counties could be required to investigate the condition of any individual who materially breaches a voluntary agreement and pursue a formal order if the person meets the AOT criteria. A standardized evaluation format should be established with benchmarks to justify the provision of enhanced services instead of filing a court petition.

Some states also have settlement agreements that are approved by a court and then have the same power as an order. Here is settlement language modified from California's Laura's Law:

(1) After a petition for an order for assisted outpatient treatment is filed, but before the conclusion of the hearing on the petition, the person who is the subject of the petition may, after consultation with counsel, waive the right to an assisted outpatient treatment hearing for the purpose of obtaining treatment under a settlement agreement, provided that an examining licensed mental health treatment provider states that the person can survive safely in the community. The settlement agreement may not exceed one year and shall be agreed to by all parties.

(2) The settlement agreement shall be in writing, shall be approved by the court, and shall include a treatment plan developed by the assisted outpatient treatment program that will coordinate the assisted outpatient treatment services.

(3) A settlement agreement approved by the court pursuant to this section shall have the same force and effect as an order for assisted outpatient treatment.

These settlement agreements would essentially be a plea bargain — with the bargaining most likely being over the treatment plan — that results in an order, which is more than putting requirements in the presently used voluntary agreements. We recommend the inclusion of a settlement agreement option as well as formalized voluntary agreements in the law. Providing a range of options that would be appropriate in different situations would promote flexibility, accountability and effectiveness.

Stabilization

Excluding whether he or she has appropriate resources, such as housing, the major factor in an individual's overall competence to participate in AOT is his or her stability. Assisted Outpatient Treatment was never meant to be a substitute for hospitalization, which is a higher level of care. The purpose of hospitalization is stabilization. The purpose of AOT is to help people who have been stabilized to achieve and maintain full stability as

a basis for recovery. AOT simply won't work if the individual's illness has not been stabilized to begin with. Unfortunately, due mostly to insurance considerations, stabilization is declining at acute care wards around the state. Where average hospital stays used to be two to three weeks, it is now three to ten days. This often is not enough time to determine whether medications are actually working.

We hear story after story of families begging facilities to keep their loved ones longer but to no avail. Such a situation not only happens to families, but also to AOT treatment teams, which have no more legal authority than anyone else to keep a person in the hospital beyond the 72-hour evaluation period. And like many families, AOT teams have brought persons to the hospital only to have them turned away. In such cases, an emergency room intern doesn't believe the person meets the hospital's admission standards — even when an AOT team psychiatrist has determined the person should be hospitalized. It is not uncommon, in such cases, for the person to return home quite ill, unstable and "at risk." That is the quandary of being turned away for the persons, families and AOT teams alike.

In an account about her daughter, who has been involuntarily hospitalized 24 times since 1995, "Brenda" from the Hudson Valley region said, "a recurring issue that I have faced during the past nine years is that my daughter is prematurely released from hospitals. She is not stable and yet she is released."

The hospitalizations immediately prior to her daughter being put on AOT, precipitated by her walking through speeding traffic on an interstate, also ended in premature releases.

"Just 84 hours after my daughter was involuntarily hospitalized, her name went up on the discharge board. This family was frantic to say the least. We knew she was nowhere near stable. We knew what she would be exposed to, if she were prematurely and inappropriately released. Our begging got us an extra 48 hours of inpatient hospitalization. She was released on March 3. By March 10 she was readmitted... During this admission she was hospitalized for a longer period of time. She wasn't released until April 19 because it took that long to get a court date in order to release her under an AOT status."

According to Brenda, a doctor had previously advised her that AOT was not really going to help her daughter, who suffers from severe bipolar disorder, obsessive compulsive disorder and an addiction to PCP, because when she cycled back into mania, the recourse would be the same: hospitalization.

Unfortunately, the doctor's words proved to be prophetic; the vicious cycle simply continued. The daughter was hospitalized again and prematurely released again. When Brenda's husband went to pick their daughter up from the hospital, he hadn't even pulled out of the grounds when he became afraid by the way she was behaving that she would jump out of the car. He called Brenda and said, "How can a doctor release someone from a hospital when they are acting like a wild animal?"

When they had a meeting with the hospital about this incident, they were informed by a social worker that some people with severe mental illness do well in a hospital setting and then "crumble" in trying to deal with the outside world. Brenda asked the social worker if she really thought her daughter had "crumbled" in the minute it had taken her to get into her husband's car.

"Without going into the details of how (you would be equally horrified in learning what led to this readmission of my daughter) we had our daughter taken by the police to the ER of a local medical facility just six days after this last discharge," she said.

Perhaps the best way to benefit from AOT in such cases is to use it as a lever to obtain intermediate or long-term care in a psychiatric center. Other families have success-

fully done so. Unfortunately, for Brenda's daughter, this has not been the case. She is now off of AOT, and the cycle continues.

While Brenda said AOT didn't help her daughter, her being assigned to an Assertive Community Treatment team has helped somewhat.

"The ACT team hasn't solved our issue of premature releases, but at least when we are in crisis I can rely on individuals who know my daughter, as opposed to "strangers" coming into the picture when I relied on the mobile crisis team," she said.

With the declining rate of actual stabilizations that we are seeing at the acute care wards in community hospitals, coupled with the continued downsizing of intermediate and long-term care facilities in New York State, we fear that AOT and ACT programs may become a dumping ground for persons in critical need of hospitalization. We are concerned that individuals may be placed on AOT as a substitute — not only for acute care but for the intermediate or long-term care they might really need. We also predict that within a few years stability itself will become a prominent issue.

The bottom line is that someone who has not been stabilized is not likely to benefit from AOT.

This brings us to the criterion for AOT that "it is likely that the person will benefit from AOT." We maintain that if an individual meets all of the other criteria for AOT but is judged not likely to benefit from it, the reason probably is that he or she has not been successfully stabilized. Frequently, these individuals have Axis II diagnoses and/or co-occurring substance abuse problems.

If a person is not likely to survive safely in the community without supervision, has a history of lack of compliance that includes hospitalizations or has resulted in acts of serious violent behavior, is not likely to voluntarily participate in recommended treatment and needs assisted outpatient treatment *but is not likely to benefit from it*, the person probably needs a higher level of care — not to be left on the street.

We recommend that a new Kendra's Law incorporate the following:

If an individual would otherwise qualify for Assisted Outpatient Treatment except that the individual does not meet the criterion that he or she will likely benefit from AOT, then the Local Governmental Unit shall conduct a review of the individual's case to ascertain, by current statutes, whether he or she is in immediate need of a higher level of care, including but not limited to involuntary hospitalization in an acute care clinic, intermediate care hospital or long-term care hospital. Such review may also be called for by the court at any hearing pertaining to the individual's AOT status, if it is found that the individual is not benefiting from AOT.

From stabilization to stability

As we said, the purpose of AOT is to move people who have been stabilized to full stability. Moving from stabilization to full stability takes time. According to our families, and several providers, it is very difficult to insure that individuals are fully stable within in the six-month initial period allotted for AOT by the current law.

For example, "Jennifer" from Long Island, whose daughter's six-month AOT is up in February, said: "As she has a 14-year history of acute illness and nonadherence, this is the longest period of time that we've seen her in some form of meaningful treatment and medication... We fear February and hope her AOT will be renewed. After 14 years, it will take longer than six months for her to gain insight and acceptance to be trusted to self-medicate and stay in treatment."

According to OMH's interim report, the average length of AOT is 11 months.

We ask that the initial period for AOT be one year, not precluding the right of the

consumer to request a hearing at any time to review and possibly terminate his or her OT.

Implementation

AOT accountability issues do not end after AOT status is granted or renewed at a hearing. The treatment plan must be carried out.

Our research found that most of the persons who are put on AOT usually carry out their end of the bargain and abide by their treatment plans. Stability — or lack of stabilization — is the major reason for those that don't. (This is why we believe that those who do not respond to AOT should be routinely considered for a higher level care.) The treatment they receive ranges from programs that have incredible success in giving persons new lives to programs where people get stuck and things go wrong, even though the worst version of AOT can still save lives.

Sometimes providers simply blunder. For example, a mother told us her family had a bad experience with AOT because her daughter, who has severe schizophrenia, was assigned to a substance abuse facility even though she is not a substance abuser. Schizophrenia is aggravated by stress, and the stress created by round-the-clock encounter groups about her supposed substance abuse put her back in the hospital.

Sometimes providers simply don't do their jobs, which is what happened to "Joan's" son in Central New York. When he began to experience severe side effects from a medication, he asked to see his psychiatrist but was told he would have to wait until his appointment a week later. He then went to a crisis center, but was turned away because he was "not in crisis." So he drank alcohol until he was so disoriented and agitated that he qualified for service in the local hospital's emergency room. Joan was called by her son's AOT caseworker from the hospital. Joan went to the hospital and reminded the caseworker that her son was not to be given the medication Haldol because he was allergic to it. This warning was already in the son's treatment plan. They gave him Haldol and he had seizures, was put in restraints and then went unconscious for four days. So much for the treatment plan.

"Jane" from Long Island related how her son, who was living in the Bronx, had to wait an entire month before receiving any services. By then, he had completely relapsed.

"Someone like my son needs daily, immediate and mandatory services. To make him wait a month was insane," she said. "I can't believe they left him alone in that disgusting apartment without any follow-up, while he was doing self-destructive things on the street. He was ready to cooperate because he thought people would be watching. It turns out that they weren't."

Sometimes providers simply go through the motions. They do not establish a real relationship with the individual they are supposed to serve.

AOT is not forced treatment as much as it is forced case management. The judge assigns a case manager to help the individual follow an agreed upon treatment plan. It is up to the case manager to create a positive, supportive relationship with the individual in order to encourage him or her to make progress. Along with what resources are available, the quality of the relationship between the individual and his or her case manager is a determining factor in the quality of service the individual receives.

We heard of several cases where AOT was all but futile because this key relationship was not there, and also of one case where AOT helped over time because of this relationship, even though services were not working.

Greater oversight by OMH over the actual implementation of AOT could catch

providers' mistakes, ensure they do their jobs and encourage them to do more than just go through the motions. AOT providers must be held accountable for what they do and don't do.

Actually, OMH Program Coordinators already have some responsibilities for monitoring services. Here are some of them:

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.

(V) THAT ASSISTED OUTPATIENT TREATMENT SERVICES ARE DELIVERED IN A TIMELY MANNER. NYS Mental Hygiene Law Section 7.17 (f) (2)

There is the ability and responsibility of Program Coordinators to make counties take action when they are not supplying services:

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. NYS Mental Hygiene Law Section 7.17 (f) (4)

Also, the law obligates AOT program directors to take action in response:

(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.

NYS Mental Hygiene Law Section 9.48 (a) (2)

With regard to OMH Program Coordinators and record review, the state Office of the Comptroller's report entitled "Office of Mental Health: Monitoring the Implementation of Kendra's Law" (page 17) states:

Officials at each of three field offices told us they periodically visit county AOT program offices. However, we found that field officials do not check county records during these visits to make sure treatment services are being delivered in a timely manner. In fact, officials at all three field offices indicated that reviewing client records is not their responsibility. In New York City, officials explained AOT is a county-run program monitored by the New York City Department of Health and Mental Hygiene, which, in turn, contracts monitoring duties to the New York City Health and Hospitals Corporation (HHC). HHC does not review provider records to verify treatment either, instead, case managers send HHC weekly verbal or faxed comments that often contain only minimal information (e.g., "Patient is compliant.") Thus, New York City is two levels of review away from actual AOT cases.

The Office of Comptroller's report continues (page 18): *We agree OMH has established a framework for operating local AOT programs, and believe OMH should continue to provide technical assistance. However, now that this framework is established, it is essential that OMH routinely verify how well it works, and document how the verification was done.*

In its response to the Comptroller's report, OMH said it will employ additional approaches to verify that services are being delivered in a timely manner, including "ride-alongs" with case managers, visits to treatment programs, reviews of Medicaid data and "a review of the medical records of persons being serviced under an AOT court order." (page 33 of the Comptroller's report).

We contend OMH must not only verify how well "the framework" is working, but, if it is not working well, intervene to fix it, in individual cases as well on a systemic level. This should not only happen in cases where services are being provided badly, but also in cases where counties are overstepping their bounds.

When discussing some of the problems with implementing AOT, an official in the state mental health system stated that it is up to the counties. As much as possible, we must make the implementation of this state law up to the state. Because it has the potential to significantly alter an individual's life for the better if implemented properly and because the stakes are so high for the individual, his or her family and their community, quality control is essential. Monitoring the judgment of providers in specific cases and the actual results of treatment, and then taking action to remedy situations where individuals are not well taken care of, are essential to quality control.

The law should be amended to add that Program Coordinators have the responsibility to monitor the actual implementation of treatment plans in individual cases and cause local AOT program directors to take corrective action whenever necessary.

Part of the quality control process should also be to listen, especially to the families, who, because of the severity of mental illness of their loved ones on AOT, should have even more of a right to be heard and to ask questions.

In all the cases where providers didn't get the treatment right, when no real relationship was established or when they simply didn't do their jobs, the families cited a lack of communication — actually a lack of listening on the providers' part.

"I must have made a million phone calls," said Jane.

"I don't see why they resist parental involvement. They're very defensive. I think they think we see things they wish we didn't see," said "Wendy" of Central New York. "There are so many flaws. It must be uncomfortable to have them seen by an outsider."

Some of the families also made an important point: "It's not just us they don't communicate with. They don't communicate with each other."

Again, if an overarching agency like OMH were more involved, communication could be facilitated with other providers and with families as well.

"It's my sense that nobody's accountable," said "Anne" from the Hudson Valley, whose son went off of AOT after six months and repeatedly landed in jail. "If it breaks down anywhere, there doesn't seem to be a way to get it going again. There's nobody whose job it is to fix it. Other than coming up with the number of people who are put on AOT, I don't see what OMH does in the process."

Financing for AOT

Although the state has supported AOT with funding, it is very difficult to determine the actual amount that is being spent on AOT services. Following is a rough breakdown of the \$32 million allocated for AOT in the 2000-2001 Executive Budget. The 2005-2006 Executive Budget also allocates \$32 million for AOT, and we believe the breakdown for this year is similar:

\$15,000,000 for medication and medication screening
(Non-AOT: medication grant program);

\$7,500,000 for additional case management
(beefing up services partly used by AOT);

\$400,000 for blood and urine testing
(AOT related but perhaps not wholly);

\$2,500,000 for additional wrap-around services
(unclear how much is AOT related);

\$2,400,000 for OMH administrative expenses
(most, if not all, for the medication grant program); and

\$4,000,000 for discharge planning
(Non-AOT: discharge from jail and prison).

Perhaps a third of the \$32 million is spent directly on AOT.

Tracking actual expenditures on AOT is difficult because it is not a discrete program; it is a level of service that involves several programs. It is currently funded through block grants to the counties, and it is up to the counties how they spend the block grant money. Many that receive funding meant to support AOT spend it on unrelated programs. There is no incentive to actively provide AOT because the funding isn't tied to performance in this area. This lack of financial accountability underlies the lack of overall accountability and could be the major reason why the quality of AOT varies so drastically from county to county.

Of course, AOT patients do receive and benefit from many community services that do not receive specific AOT funding, (for example, supported housing) as part of their treatment plans. It is as difficult to determine how much non-AOT funding has gone to AOT patients as it is to know how much AOT funding has gone to people who don't qualify for AOT. The incentive question remains, however.

We recommend changing the AOT funding formula to consist of a "base" block grant and supplemental quarterly payments based on the actual number of persons provided with AOT.

Summary

When Kendra's Law was first proposed, it was extremely controversial, and our members were divided over whether to support it. Today, an overwhelming majority of our members support it, including many who were originally against it. It is a law that is more needed than ever, even when it is only being used the way we think it shouldn't: as a last resort for persons who have been prematurely released from hospitals, who desperately need to stay on their medications.

When properly implemented, AOT can work well:

"In my experience, the AOT team has been absolutely of the highest caliber: caring, concerned and professional," said "Susan" from New York City, about an AOT team in Queens. "AOT has made a real difference for my son."

"They did everything right," said Kate about her experience with AOT providers New York City. "It was a cooperative effort, and it served its purpose. My son did incredibly well when he was on AOT."

Things can go wrong when AOT is not properly implemented, but even then, it can be better than nothing. As "Nancy" from New York City related, "I was asked how I thought

the AOT was going, and I said I didn't think it was going that well. Then they didn't renew my son, and that was the worst thing in the world that could have happened. I didn't mean they shouldn't renew it."

Of the 20 families who had a loved one on AOT that we interviewed, 11 enthusiastically endorsed it, six endorsed it without much enthusiasm, as still better than what they had before, and three said it didn't work well enough for them to endorse.

What is the determining factor between success and disappointment with AOT? "You really have to be lucky," one mother said.

Much of the luck one needs depends upon what county one resides in, and whether the providers in that county take the law seriously. This includes what the counties do with the money they receive to help them implement AOT. It's at their discretion how they use it, and it has been used for a number of programs that do not benefit the AOT population. There appears to be no financial incentive to do otherwise.

Some counties do not even participate in the program to supply newly released inmates with medications until they can get back on Medicaid. Many persons with serious mental illness who are released from jail simply can't make it without medications until they get back on Medicaid.

Receiving good AOT services should be more than a matter of chance. The Office of Mental Health must be given the responsibility to ensure that counties carry out the law and provide meaningful services on a case-by-case basis. In its last Comprehensive Statewide Plan, the Office of Mental Health describes a reform agenda called the "ABCs" — Accountability, Best Practices and Coordination — as the "framework" of its strategic planning. OMH must apply the ABCs to AOT programs.

As in any system, the doers must be rewarded and the deadbeats must not be rewarded.

Speaking about its current evaluation system in response to the state Office of Comptroller's Report, OMH said the purpose of the current system is to review the impact of the overall AOT program and not to track individual cases. Now that the overall program has proven itself, it is time to take the next step. For each "statistic," there should be a personal story of increased quality of life.

Promoting accountability is not just a matter of empowering the state office, however. Those who have a direct stake in their loved ones' improvement, the families, must also be more empowered.

A common denominator of the successful AOT cases is the involvement of families. "Kate" from New York City, whose son did "incredibly well," said, "Our family was involved in the treatment. Without family support, nothing works."

A lack of communication, with families and in general, is a common denominator of the disappointing AOTs.

Besides taking these steps to empower OMH and families, there are certain other issues the law must address in order for it to work better. Following are the recommendations that have been made throughout this report to accomplish what needs to be done to improve this law.

A guideline is a statement of policy or principle, whereas a regulation is a governmental order having the force of law. AOT itself is governed only by guidelines in its implementation on the local level. Going with guidelines enabled the state to begin AOT quickly, within 90 days after it was enacted. Making regulations is an onerous process that is traditionally reserved for those programs, such as Medicaid programs, that are mandated to have them. Several of the changes in the law we recommend are in lieu of regulations.

Kendra's Law truly was landmark legislation, with a potential impact on mental

health care as significant as deinstitutionalization and reinvestment. If imitation is a great compliment, other states have been very complimentary of the law. California has enacted Laura's Law, modeled on Kendra's Law. Both Florida and Michigan have updated their AOT laws, which weren't working, to laws modeled on Kendra's Law. New Jersey has Gregory's Law, modeled on Kendra's Law, pending in its legislature.

It is now time to make Kendra's Law permanent and move it forward, mostly by providing for more accountability. AOT can be very effective, not only in saving lives but in improving quality of life. The task now is to make it more effective.

Recommendations

1. Kendra's Law must be made permanent.

2. The Office of Mental Health must be given the responsibility to ensure that localities carry out the law and provide meaningful, high-quality services on a case-by-case basis. OMH and its AOT Program Coordinators must access case records directly and, upon the request of an individual's family or the party that requested the original investigation, must investigate specific AOT cases where the county had declined or failed to act — whether it was a failure to investigate, to submit a petition, to provide services called for by the treatment plan or to correct service deficiencies — and, if it is in the best interests of the person and the community involved, direct the county to take specific actions.

In cases where counties have declined or failed to act — whether it was a failure to investigate, to submit a petition, to provide services called for by a treatment plan or to correct service deficiencies — families must have a means of redress through the AOT Program Coordinators.

3. Families must be given the right to petition courts with evidence showing that, if their counties conducted a proper investigation, their loved ones would likely qualify for AOT, and a judge must have the authority, based on such evidence, to order a Local Governmental Unit to release medical records for evaluation by an independent physician or to order the LGU to either establish that it performed an appropriate investigation or to conduct one. Families must be awarded court costs, including attorney's and physician's fees, if they prove their counties should have conducted such investigations.

4. Investigations must be completed in no more than 30 days, unless there are documented extenuating circumstances, and when that time is up, both the person who requested the investigation and the local OMH Program Coordinator must be apprised of its outcome.

5. If a county determines a person does not qualify for AOT, whoever requested the investigation must be told which of the criteria the person does not meet.

6. The law must also provide that local courts designate specific judges for AOT hearings and lawmakers must urge, in the Message of Intent, that those judges be educated on the law and on mental illness itself.

7. AOT court orders must be transferable to other county AOT program coordina-

tors, and a procedure to accomplish this must be put in place.

8. Contracts for voluntary agreements must be given legal standing with required standards. Also, a standardized evaluation format must be established with benchmarks to justify providing enhanced services instead of filing a court petition.

9. Settlement agreements must be included in the law to provide a court-sanctioned alternative to voluntary agreements.

10. If the sole criterion for denial of AOT is that the person is not likely to benefit from it, then the person's case must be reviewed to determine if he or she needs immediate placement in a higher level of care.

11. The initial period of AOT must be one year.

12. Finally, the funding formula for AOT services must be changed to include quarterly supplemental payments based on the actual number of persons who are served by AOT.