Kendra's Law

An Interim Report on the Status of
Assisted **O**utpatient **T**reatment

New York State 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 (Appendix 1 contains a copy of Kendra's Law; Appendix 2 contains an analysis of court decisions relating to Kendra's Law). 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 and the resulting AOT program on local mental health systems and on individuals receiving court-ordered services. In this interim report, required by the Kendra's Law statute, we review the implementation and current status of AOT and present findings from OMH's ongoing evaluation of the program.

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; and 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. 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 any other necessary services. Kendra's Law required that each county in New York State and New York City establish a local AOT program to implement the statute's requirements, and charged OMH with responsibility for developing AOT program guidelines and monitoring AOT statewide. Thus, 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 thirty-six months; or

   b. resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight 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 FY2000-2001 included $32 million for implementation of Kendra's Law. This appropriation supported case management and other services aimed at keeping recipients in a treatment program, including psychiatric medication as required. Shortly after Kendra's Law went into effect, Governor Pataki 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 FY2000-2001 also included $125 million in new funding for such services. This "New Initiatives" funding, which comprised the largest single investment in the public mental health system in NYS history, was 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, the New Initiatives were designed to steer the NYS mental health system toward a more person-centered, recovery-oriented service delivery approach. The New Initiatives 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

During the period between enactment of the legislation and the effective date of

November 7, 1999, OMH staff developed and disseminated guidelines necessary for implementation and operation of AOT statewide. In November 1999 counties across NYS created and operationalized the mechanisms necessary to implement AOT locally.

At the local level, County (or City of New York) Mental Health Directors operate, direct and supervise their AOT programs. Local Mental Health Directors coordinate delivery of court-ordered services, file petitions, and receive and investigate reports of persons who may be in need of AOT. They also insure AOT service delivery by directly providing services, coordinating with OMH services, and/or utilizing not-for-profit programs.

OMH plays a key role in the oversight of AOT. The OMH Commissioner appoints Program Coordinators who monitor and oversee operation of AOT across NYS. Each OMH Field Office has an AOT Program Coordinator. The OMH AOT Program Coordinator works with local mental health directors, oversees and monitors care provided to persons under AOT, and can require local Directors of AOT programs to take corrective action if court-ordered services are not delivered in a timely manner. In addition, OMH's oversight role is enhanced by data collected on an ongoing basis for the evaluation of AOT.

Common Components of Local AOT Programs

During the first year of the program OMH conducted an evaluation of AOT implementation in a geographically representative sample of localities. The study was conducted in eight counties and New York City with full collaboration of local mental hygiene directors in those localities. Data were collected through interviews with multiple stakeholders and observation of processes associated with the implementation of AOT. Stakeholders included mental health care coordinators, other mental health service providers, county government personnel, court system staff, family members of persons with mental illness, persons under AOT and other mental health service recipients.

Visits to each study site allowed for direct observation of the mechanisms localities developed to implement AOT. Figure 1 depicts a schematic representation of the major components (personnel and processes) of the AOT program as it has been implemented in each of the nine study sites. Discussions with OMH regional AOT Coordinators and local AOT program staff from counties not included in the study suggest that the model displayed in Figure 1 is representative of AOT as implemented in most areas of NYS.

As illustrated in Figure 1, the AOT program consists of four core phases or processes - referral, investigation, assessment and service delivery/monitoring. In the referral phase, an individual becomes known to the local AOT coordinator either through a direct referral from the community, or through a referral made by a local hospital or correctional facility. Upon referral, the AOT coordinator or an AOT Team (usually led by the AOT coordinator) initiates an investigation. This is conducted to ascertain an individual's potential eligibility for AOT. If an individual is determined to meet the eligibility criteria, an AOT case review panel assesses the needs of the individual and determines whether a court-ordered treatment plan or a non-court-ordered service enhancement should be pursued. If a court-ordered treatment plan is determined to be appropriate, the court is petitioned to consider issuing a court order requiring the individual to adhere to a treatment plan. Upon issuance of the court order, the individual receives a care coordination service (case management or ACT) and other court mandated services needed to help insure success in the community. Initial court orders last six months and upon expiration, can be renewed for up to one year.

As localities began to identify individuals who were in need of AOT, they also identi-

Schematic representation of AOT processes in nine areas of New York State

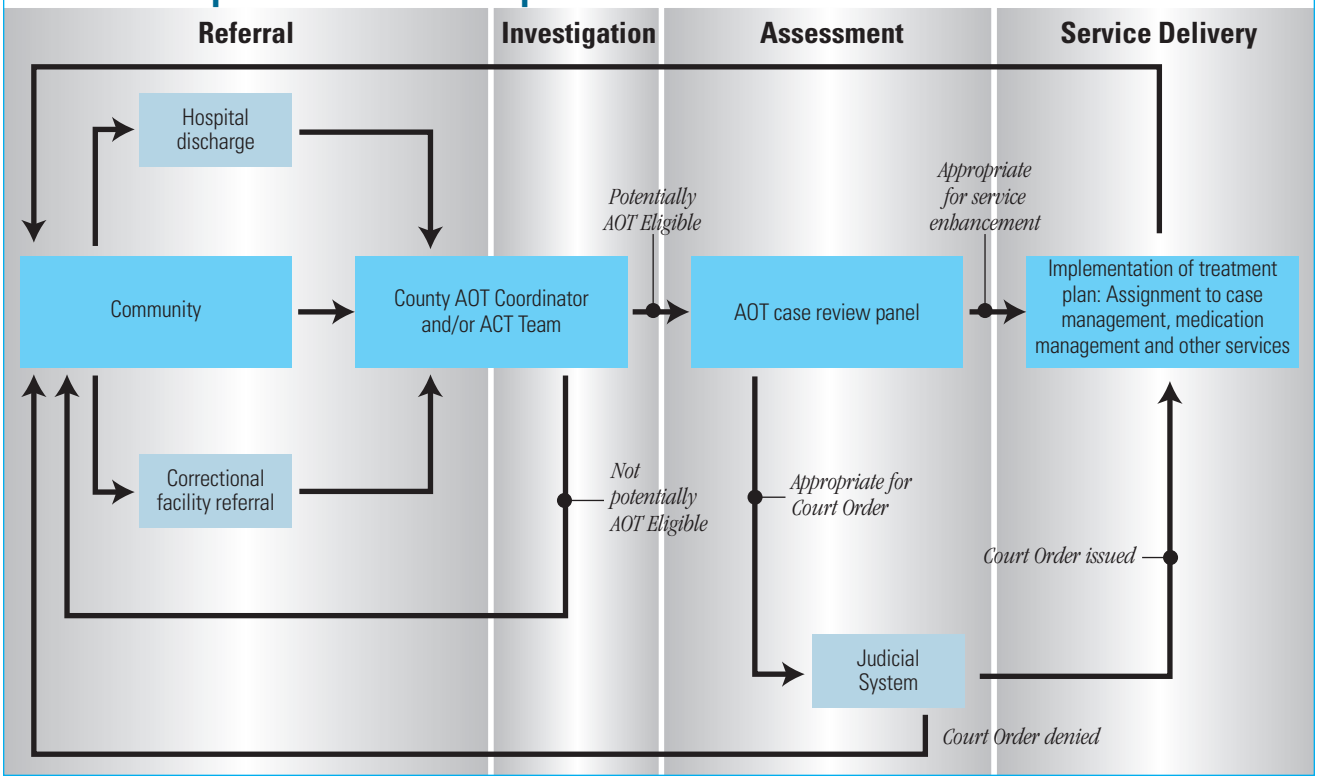


Figure 1

fied other individuals who did not require court-ordered treatment but nevertheless had unmet service needs. Many of these individuals were willing to voluntarily participate in necessary services. In some areas of New York State these "service enhancements" can also include a signed service agreement, special reporting requirements for assigned case managers and increased monitoring of cases by the county. These voluntary service enhancements represent an additional unanticipated benefit from the implementation of Kendra's Law.

Impact of AOT on Local Mental Health Systems

Stakeholder interview data from the AOT implementation study document the perceived impact of AOT on local service delivery from a variety of perspectives. Below, we present major themes that emerged from analysis of interview transcripts.

In each locality included in the study, and across multiple stakeholder groups, there was broad recognition that the implementation of processes to provide AOT to high risk/high need recipients 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, represent new points of accountability in local mental health service systems.

Some areas of NYS have established sitting AOT Teams that are staffed by individuals who can effectively exert "clout" within their service systems. These are individuals who, through personal contact with providers, can ensure either initial access to services or can intercede on behalf of an individual who is not receiving the appropriate attention. They can move the system to meet the needs of persons who come to the attention of the team either as new persons under AOT or

individuals who are being monitored while under court order or receiving enhanced services. Specific enhancements reported by stakeholders across counties include:

Enhanced Accountability and Improved Access to Services. 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.

Improved Treatment Plan Development and Discharge Planning. There was general agreement among stakeholders that processes and structures developed for AOT have resulted in improved treatment plans which more appropriately match the challenging needs of individuals who had been previously difficult to engage. The AOT processes put in place have increased attention to the needs of individuals who are referred. Clinicians are carefully considering the needs of individuals and are developing sound comprehensive treatment plans that will best ensure success in the community.

Improved Coordination of Service Planning. AOT provides a mechanism to bring together high-level representatives of appropriate service providers to consider eligibility and strategies for service delivery to AOT eligible individuals. The make-up of these panels varies and reflects local conditions. AOT coordinators and care coordination (e.g., case management, ACT) gatekeepers are consistently present. In some areas ongoing coordination efforts are expanded to include county attorneys, recipient advocates, and psychiatrists.

Improved Collaboration between Mental Health and Court Systems. Over time, staff from the mental health system have developed better relationships with the court system. In speaking to study participants associated with both systems, it was clear that a certain level of uneasiness in the relationship between these two systems was common. As AOT processes matured, professionals from these two systems learned how to improve needed interactions. Mental health practitioners learned how to negotiate the court systems in which they were required to operate. They confronted the challenge of rotating judges by learning how to best prepare for court proceedings. These adjustments have led to an enhanced efficiency in the conduct of AOT hearings, an efficiency that will more likely result in meeting the clinical needs of individuals.

In summary, the AOT implementation study found that important changes to local mental health systems have come about as a result of the AOT program. More specifically, there was general agreement that AOT has led to enhanced service system structures that promote better accountability, improved access to services for high need individuals, improved treatment plan development and discharge planning, improved coordination of service planning and a more collaborative relationship between mental health and court systems.

AOT Program Status

OMH maintains an evaluation database to monitor AOT program status, the characteristics of AOT recipients, service delivery under AOT, and program outcomes. OMH Central and Field Office staff record basic information on each court order issued and the status of each court order. Case managers serving AOT recipients complete standardized assessments for each recipient at the onset of the court order (baseline) and at 90 day intervals thereafter. The resulting database includes information on:

- general demographic characteristics of individuals, status of individuals in such

areas as living situation, education and employment, services received, engagement in services, and adherence with prescribed medication;

- incidence of significant events such as hospitalization, homelessness, arrest and incarceration; and

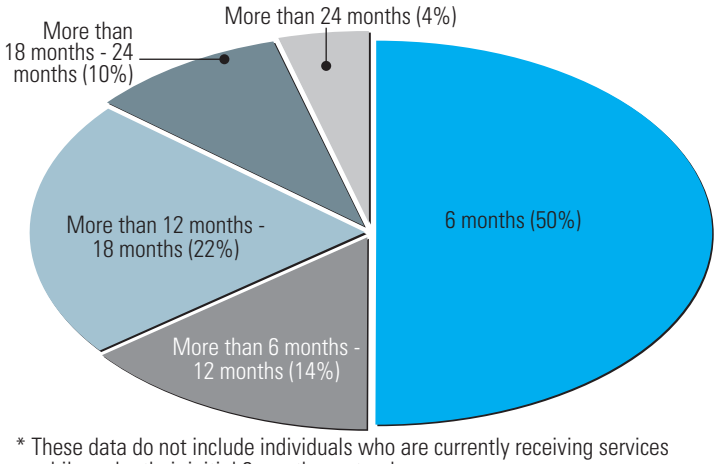
- functional assessments in the areas of self-care, social skills and task performance, and the incidence of behaviors harmful to the individual or others.

Volume of AOT Investigations, Court Orders and Service Enhancements

From November 1999, through December 3, 2002, 7,938 individuals have been referred to local AOT coordinators for investigation to determine potential eligibility for an AOT court order. Thirty-three percent or 2,559 of these have resulted in petitions filed for the issuance of an AOT court order; of these, 95% or 2,433 resulted in a court order being issued. Twenty percent (1,541) of the total number of investigations have resulted in service enhancements rather than court orders.

Figure 2

Distribution of Time Spent Under AOT Court Order
November 1999 - December 2002



* These data do not include individuals who are currently receiving services while under their initial 6 month court order.

Court orders and service enhancements have been issued in all regions of NYS. Sixty-five percent of all court orders and service enhancements and approximately 77% of court orders occur in New York City. More than half of all court-orders issued (55%) are renewed. Table 1 summarizes data on outcomes of the judicial procedures associated with AOT.

Table 1
Outcomes of Judicial Proceedings Associated with AOT
New York State (Through December 3, 2002)

Number of Referrals/Investigations	7,938
Number of Petitions Filed	2,559
Number of Petitions Granted	2,433
Percentage of Petitions Granted	95%
Number of Orders Eligible for Renewal	2,038
Number of Orders Renewed	1,120
Percentage of Orders Renewed	55%

Figure 2 displays the distribution of total time spent under court order. On average, individuals who are issued court orders are in that status for nearly 11 months. As of December 3, 2002, the longest any individual had received services under an AOT court order was 35 months.

Characteristics of AOT Recipients

Demographics. Table 2 below displays data on the age, sex, race/ethnicity, marital status and living situation of AOT service recipients. On average, persons under AOT are 37 years of age and two-thirds (68%) are male. Most are unmarried and are living in independent settings in the community. Sixty-one percent are living in such settings, alone or with parents, spouses, friends or other relatives.

The racial and ethnic composition of the population receiving court-ordered treatment is diverse. Forty percent of individuals under AOT are Black, 29% are White and 21% are

Table 2
Demographic Characteristics of AOT Recipients

Age	
Mean Number of Years	37 years
Gender	
Male	68%
Female	32%
Race/Ethnicity	
Black (Non-Hispanic)	40%
White (Non-Hispanic)	29%
Hispanic	21%
Asian/Asian-American	3%
Other	5%
Marital Status	
Single, never married	74%
Divorced	11%
Married	6%
Other	9%
Current Living Status	
Lives alone	16%
Lives with others	45%
Supervised living or Assisted/supported living	20%
Other	19%

Hispanic. The racial and ethnic characteristics of AOT recipients are similar to those of other individuals receiving intensive case management services. A comparison of AOT court-ordered individuals in New York City with a similar population of individuals receiving intensive case management services prior to the implementation of AOT show that there are no statistically significant differences between these populations in regard to race and ethnicity.

Diagnoses. Most individuals (70%) receiving an AOT court order have a diagnosis of schizophrenia. Thirteen percent have a bipolar disorder diagnosis. A majority (60%) 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 3 summarizes the incidence of hospitalizations, homelessness, arrest and incarceration for persons under AOT prior to court-ordered treatment. In the three years prior to the court order, 91% of individuals had at least one psychiatric hospitalization. On average, these individuals had been hospitalized nearly three times during that period with some individuals having had as many as five hospitalizations. Twenty percent of individuals had experienced at least one episode of homelessness in the three years preceding their court order. Twenty-nine percent were arrested at least one time in the three years prior to AOT. These individuals had as many as eight arrests during that time. Eighteen percent were incarcerated at least once in

Table 3
Incidence of Hospitalization, Homelessness and Arrest and Incarceration Three Years Prior to Issuance of Court-Order

Psychiatric Hospitalizations	
Mean number in last 36 months	2.94
Percent hospitalized (at least one episode)	91%
Number of admissions (range)	0-5
Homeless Episodes	
Mean number in last 36 months	0.27
Percent homeless (at least one episode)	20%
Number of episodes (range)	0-5
Arrests	
Mean number in last 36 months	0.50
Percent arrested (at least one episode)	29%
Number of arrests (range)	0-8
Incarcerations	
Mean number in last 36 months	0.25
Percent arrested (at least one episode)	18%
Number of incarcerations (range)	0-5

the three years prior to their court order. Some individuals had as many as 5 incarcerations in those three years.

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 prior to their court order and 50% more likely to have had a previous episode of homelessness. In addition, individuals who have received an AOT court order were 50% more likely to have a co-occurring substance abuse problem.

Outcomes for AOT Recipients

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 under AOT the goal is 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 should result in improved adherence with prescribed medication and decreased hospitalization, homelessness, arrests and incarceration. In addition, individuals under AOT should benefit through improved functioning in important community and personal activities.

Increased Participation in Case Management and Other Services

Table 4 compares participation in services by AOT recipients prior to and subsequent to the 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. The most 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 52% of these individuals were receiving this service.

In addition, the percentage of AOT individuals who are receiving substance abuse services doubled as a result of their court-ordered

Table 4
Services Received by Persons Under AOT in New York State Rates Prior to AOT and While Enrolled in AOT

	Percentage of Persons Under AOT	
Service	Prior to AOT	While Enrolled in AOT
Case Management	52%	100%
Medication Management	63%	94%
Individual or Group Therapy	51%	75%
Day or Partial Hospitalization	15%	35%
Substance Abuse Services	26%	52%
Housing and/or Housing Support Services	23%	41%
Urine or Blood Toxicology (adherence to medication)	17%	27%
Urine or Blood Toxicology (substance abuse)	16%	25%
Other	4%	9%

treatment plan, increasing from 26% to 52%. Similarly, the percentage of persons under AOT who receive housing services as a result of their court-ordered treatment plan nearly doubled, increasing from 23% to 41%. Substantial increases are also seen for urine or blood testing used to assess adherence to medication or substance abuse.

Reduced Incidence of Hospitalization, Homelessness, Arrest and Incarceration

After six months of participation in AOT, the incidence of hospitalization, homelessness, arrest and incarceration had all declined significantly from their pre-AOT levels. Table 5 summarizes change in the occurrence of these events.

Table 5
Change in Incidence of Significant Events for Persons Under AOT
(Percent of all AOT Recipients)

	Prior to Onset of a Court Order	During AOT
Psychiatric Hospitalization	87%	20%
Homelessness	21%	3%
Arrests	30%	5%
Incarcerations	21%	3%

Increased Engagement in Services and Adherence to Prescribed Medication

An important goal of AOT is increased engagement, i.e., active and regular participation in services; and increased adherence to prescribed medication, i.e., taking medications necessary to manage psychiatric symptoms as directed by the treating physician. To assess engagement, case managers were asked to rate the engagement of persons under AOT using a scale ranging from "not at all engaged in services" to "independently and appropriately uses services." Data collected since the onset of AOT show the percent of individuals who exhibit poor engagement dropped significantly from 59% to 34% at six months.

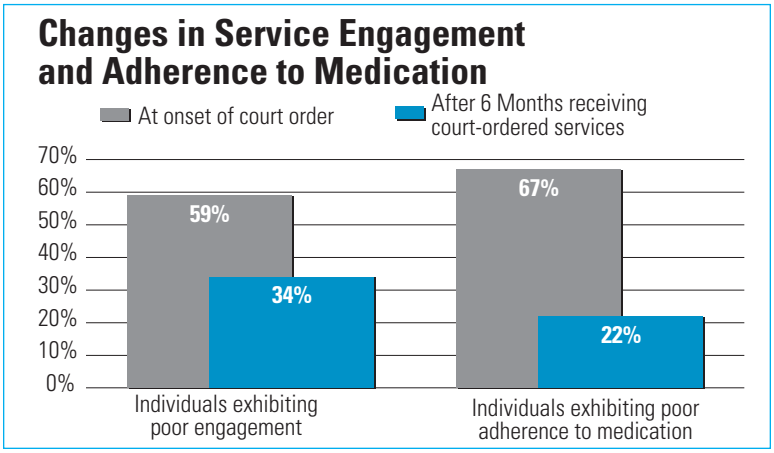
To assess medication adherence, case managers were asked to rate adherence of persons under AOT using a scale ranging from "taking medication exactly as prescribed" to "rarely or never taking medication as prescribed." The resulting data show that the percent of individuals with poor medication adherence dropped significantly from 67% to 22% after six months. Figure 3 displays the improvement in engagement in services and medication adherence 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 case manager serving the individual under AOT completes all functional assessment measures.

The GAF is a commonly used measure of overall functioning. It includes social, occu-

Figure 3



pational, 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 38% 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 31%.

AOT recipients' functioning in the area of self-care and community living also improved after six months of program participation. Figure 4 displays the change in these measures. The figure compares the percentage of persons under 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 12 of the 13 measures the change was statistically significant.

In the area of social, interpersonal and family skills and task performance, similar improvements in functioning were seen. On all measures for these areas, the changes between the onset of the court order and at six months were statistically significant. Figures 5 and 6 display the social, interpersonal and family skills and task performance data.

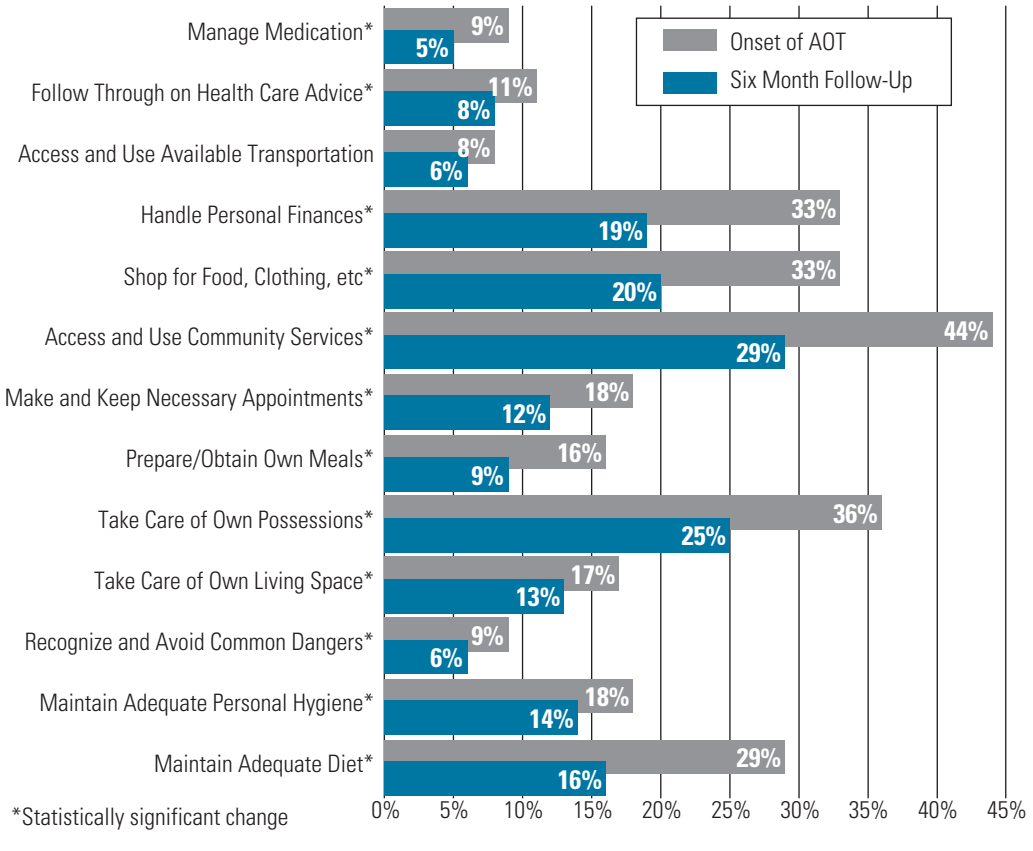
Decreased Incidence of Harmful Behaviors

Case managers also reported reductions in the incidence of harmful behaviors for persons under AOT. All 11 harmful behaviors rated showed declines in the percentage of

Figure 4

Improvement in Self Care and Community Living

(Percent of Persons Reported Having Severe Difficulty)



*Statistically significant change

Improvement in Social, Interpersonal and Family Functioning

(Percent of Persons Reported Having Severe Difficulty)

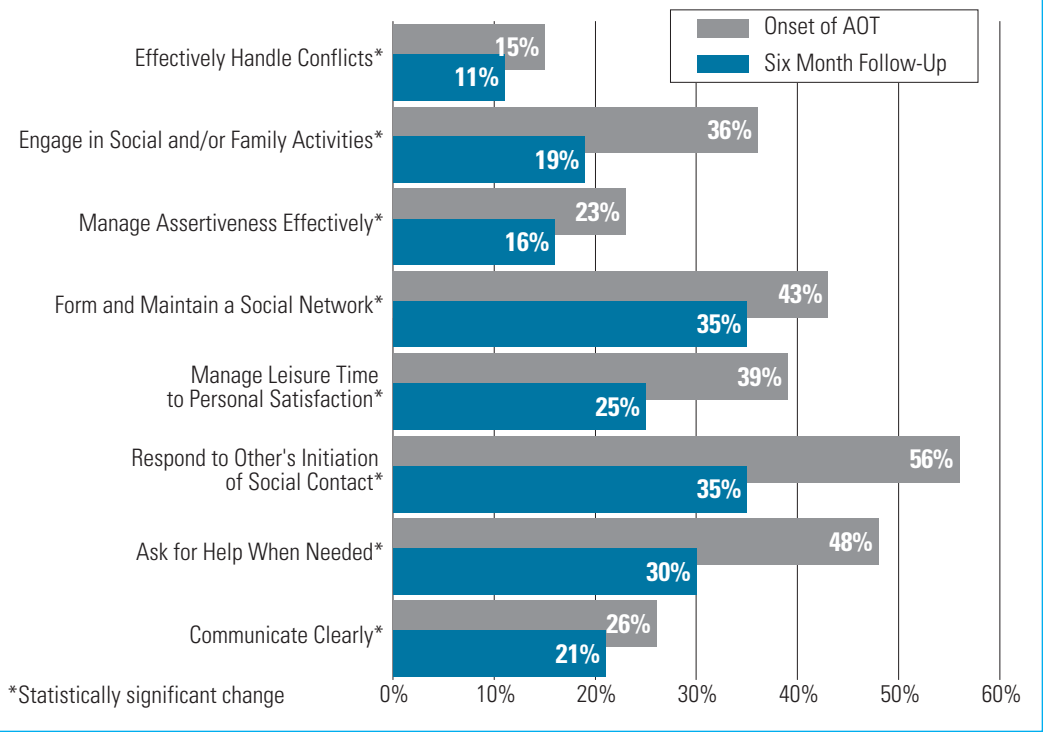


Figure 5

Improvement in Task Performance

(Percent of Persons Reported Having Severe Difficulty)

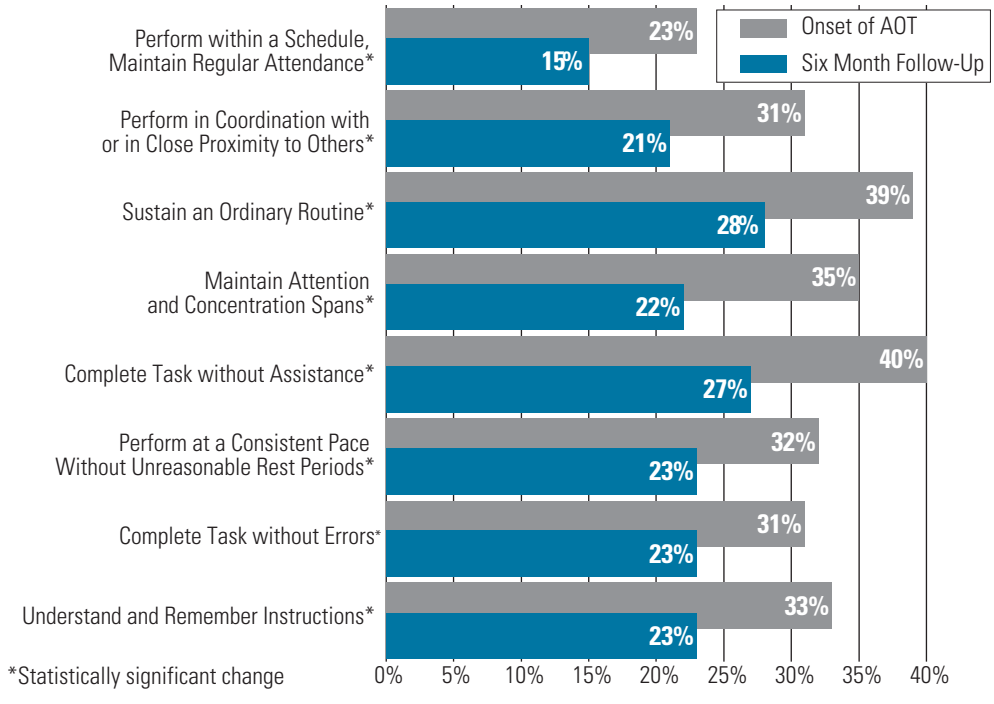


Figure 6

individuals for whom an occurrence was reported. The reductions in 10 out of 11 harmful behaviors were statistically significant. Figure 7 presents these data.

In summary, individuals receiving AOT court orders showed improved functioning in the areas of self care, community living, interpersonal functioning and task performance during the first six months of court-ordered treatment. Incidence of psychiatric hospitalization, homelessness, arrests and incarceration decreased from pre-AOT levels. Statistically significant reductions also occurred in harmful behaviors such as substance abuse, suicide attempts, and physical harm to self.

Status of Persons Under AOT at Court Order Termination

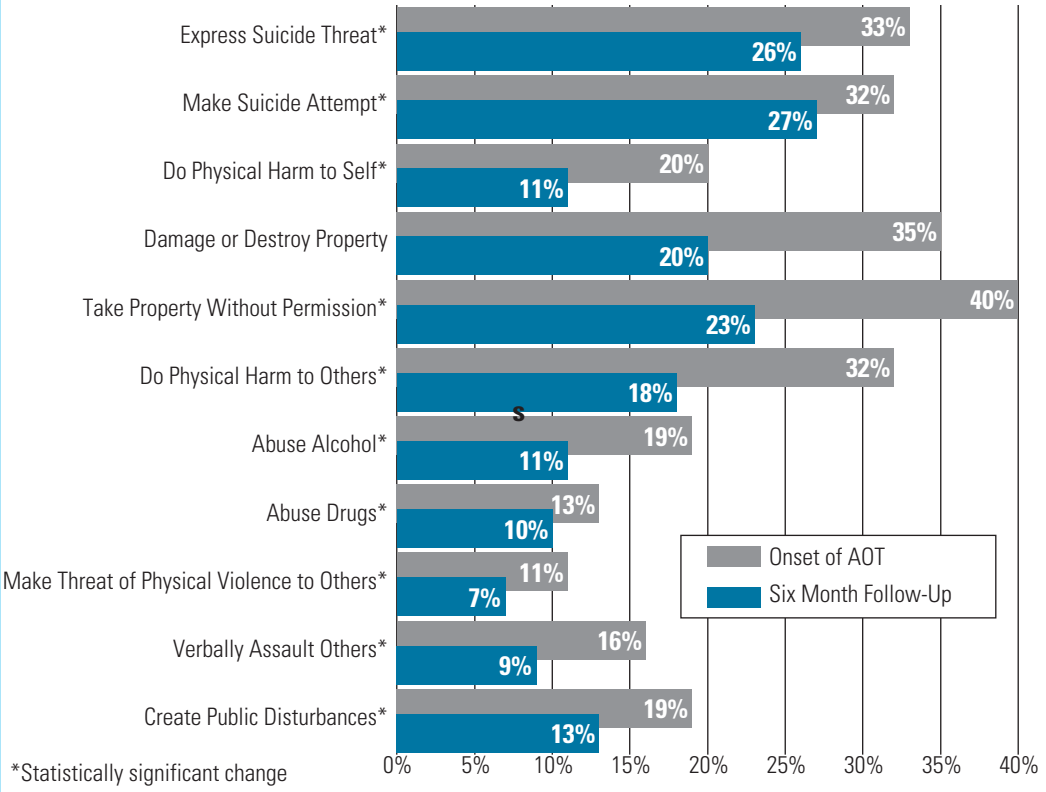
This section describes the status of AOT recipients when their court-order is terminated. Figure 8 displays the distribution of reasons for termination of court-ordered treatment. The most frequently cited reason is that the individual has improved and is no longer in need of AOT (66%). The next most 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 (14%).

At the time of court order expiration most individuals were living either in independent or supervised community-based settings. Forty-four percent were living in independent settings, alone or with parents, spouses, other relatives, or other persons. Twenty-one percent

Figure 7

Improvement in Incidence of Harmful Behaviors

(Percent of Persons for Which One or More Events in the Past 90 Days is Reported)



*Statistically significant change

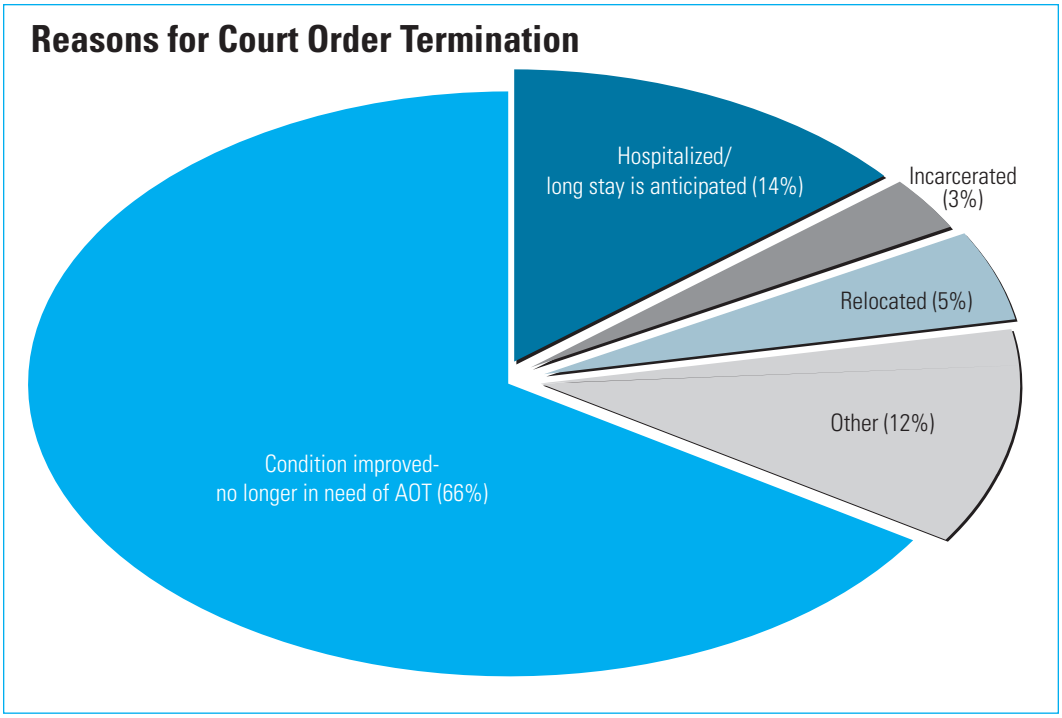


Figure 8

were living in either assisted/supported living or supervised living settings. Nineteen percent were in psychiatric inpatient settings, while three percent were incarcerated at the time their court order expired.

Next Steps

The Office of Mental Health will continue to monitor the characteristics and outcomes of persons who are under court order. No recommendations for statutory amendment to Kendra's Law are recommended at this time.

Evaluation results are reviewed monthly in a quality improvement process with the goal of identifying opportunities for program improvement and policy change. In addition to OMH's ongoing AOT program evaluation and monitoring activities, OMH researchers, in collaboration with researchers at the Columbia University Mailman School of Public Health, have launched a controlled study to establish the effectiveness of AOT in the reduction of harmful behaviors, incarceration and psychiatric hospitalization. A final report on the AOT program is due to the Governor and Legislature on March 1, 2005.

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 voluntary 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

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

accept individual 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 preclude 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 super-

vising 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 provide 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 seventytwo 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 article 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, 2,433 court orders have been issued for AOT statewide, together with 1,120 renewal 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 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 months[7] 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:

Brennan, K.J. (2002). Recent developments under Kendra's Law. New York State Bar Association Journal. Volume 7, No 2, 24-34.

1.) an adult (18 years or older) roommate of the person;

2.) a parent, spouse, adult child or adult sibling of the person;

3.) the director of a hospital where the person is hospitalized;

4.) the director of a public or charitable organization, agency or home that provides mental health services and in whose institution the person resides;

5.) a qualified psychiatrist who is either treating the person or supervising the treatment of the person for mental illness;

6.) the director of community services, or social services official of the city or county where the person is present or is reasonably believed to be present; or

7.) a parole officer or probation officer assigned to supervise the person.[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.) n 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, 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

In In re Urcuyo,[21] the first court challenge to the constitutionality of Kendra's Law, the 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 standard for such 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 patients 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 stan-

dards. 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. Hogue[28] 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.

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 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 reasoned 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, while Rivers reaffirmed the right of every individual to determine his or her own course of treatment, the court 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 the Rivers analogy was deemed inappropriate, the court went on to analyze whether the deprivation of a patient's liberty interests occasioned by a Kendra's Law order represented a constitutional exercise of the State's police or *parens patriae* powers. In light of exhaustive legislative findings, and "elaborate procedural safeguards to insure the protection of the patient's rights,"[34] 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.[35]

Respondent's 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, 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. [36]

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,[37] 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.

Although Kendra's Law was declared "constitutional in all respects," by the court in Matter of K.L., [35] the decision has generated an appeal to the Second Department by respondent. In addition to opposition by the petitioner, 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 outcome of that appeal will determine the extent to which the constitutionality of the statute remains an issue.[36]

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, a debate emerged 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:

(1) 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:

(2) 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, [37] 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.[38]

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."[39]

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.[40]

The decision in Matter of Dailey,[41] 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"[42]

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." [43]

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.,[44] 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.[45]

Hector A. cited with approval the rationale articulated in Julio H.,[46] 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 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."[47] 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.[48]

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.,[49] 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.[50] 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.[51]

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."[52] 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.[53]

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 circumstances 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.[54]

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.[55]

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 F.,[56] 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.[57]

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 affirmance, 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.[58] 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.,[59] 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 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] sufficiently 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.[60]

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.,[61] 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. [62]

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."[63]

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.

In Jesus A., although there was a dispute over whether petitioner had met its evidentiary burden, it was without dispute the petitioner's burden. In Matter of Anne C.,[64] the court was asked to construe M.H.L. 9.60(m), and determine the allocation of the burden of proof in a jury appeal of a Kendra's Law order.

Respondent was the subject of an AOT order, and as the expiration of the initial six month order approached, an application was filed for an extension of the original order for an additional twelve months. Respondent failed to move in opposition to the extension, but after the extension was granted, demanded a jury trial to "review" the extension order.

Kendra's Law contains an appeal provision, which incorporates by reference the procedures found in M.H.L. section 9.35, which permit jury review of retention orders. The court construed that provision, as incorporated into Kendra's Law, to guarantee Kendra's Law respondents the right to the type

of review contemplated by Article 55 of the CPLR.[65]

By characterizing a request for review under 9.60(m) as an appeal, the court identified the respondent as the appellant. This is significant, because respondent had argued that 9.60(m) guaranteed the right to a rehearing. In a rehearing, the petitioner would be forced to carry the burden of demonstrating by clear and convincing evidence that all of the statutory criteria had been met. By denominating the respondent the appellant, the tables are turned, and now the respondent must carry the burden of demonstrating that the criteria had not been met.[66] Further, the court held that the respondent/appellant was bound by the same standard of proof in its appeal as the petitioner had been at the hearing itself — she must prove that the criteria had not been met by clear and convincing evidence.[67]

Finally, respondent asked the court to consider the changes in her condition and circumstances, since the order was issued. The court rejected respondent's request, and instead held; first, the proper mechanism for staying, modifying or vacating an existing order is provided by M.H.L. 9.60(1), not the jury appeal permitted by M.H.L. 9.60(m), and second, because it is an appeal, and not a motion to modify, the jury may not consider any new evidence.[68]

The decision in Anne C. has spawned some discussion, because although it purports to adopt M.H.L. s. 9.35 procedures, it describes a process which seems to depart from the typical 9.35 retention hearing scenario. In any event, the respondent in Anne C. has appealed the decision, and the result of that appeal should provide guidance for practitioners seeking jury review of Kendra's Law orders.

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,[69] 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.[70] 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.[71]

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."[72]

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. [73]

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.[74]

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.

Kendra's Law provides for the review of an order granting a petition before a jury, and such an appeal will ostensibly follow the same procedures as in a section 9.35 retention hearing. However, on at least one occasion this provision has been judicially construed as having the character of an appeal pursuant to Article 55 of the CPLR, where the burden of proof shifts to the appellant.

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 November 1, 2002.
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 11.
37. 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 (2nd 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.
35. Id., at 14.
36. The case was argued before the Appellate Division, Second Department, on November 7, 2002.
37. Matter of Sarkis, (NYLJ, Aug. 18, 2000, at 29, col 6).
38. Id.
39. Id.
40. In the Matter of South Beach Psychiatric Center, etc., respondent; Andre R., 727 N.Y.S.2d 149, 150 (Second Dept. 2001), (citations omitted)
41. Matter of Dailey, 713 N.Y.S.2d 660, (Sup. Ct. Queens County, 2000).
42. Matter of Dailey, 713 N.Y.S.2d at 663 (emphasis in original).
43. In the Matter of Pilgrim Psychiatric Center v. Anthony F., 18601/01 (S.Ct. Suffolk Cty, 2002), (Order Denying Motion to Dismiss Kendra's Law Petition).
44. In the Matter of Weinstock, appellant: Hector A. (Anonymous), respondent, 733 N.Y.S.2d 243 (Second Department, 2001).
45. Id., at 245.
46. 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).
47. Id., at 619.
48. 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.
49. 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).
50. M.H.L. section 9.60(e)(3)(i).
51. M.H.L. section 9.60(h)(4).
52. Matter of Nathan R., 710 N.Y.S.2d at 805 (quoting respondent's counsel).
53. Id., at 805.
54. Id., at 806.
55. Id.
56. Amin v. Rose F., (NYLJ, December 7, 2000, at 31, col 1).
57. Id.
58. In the Matter of Rose F. v. Amin, 739 N.Y.S2d 834 (Second Dept. 2002).
59. 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).
60. Id., at 189.
61. 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).
62. Id., at 857 (citations omitted).
63. Id. (Citations omitted).
64. Cohen v. Anne C., 732 N.Y.S.2d 534 (Sup. Ct. New York County, 2001).
65. Id., at 541.
66. Id., at 542-543.
67. Id.
68. Id.
69. In re Application of Manhattan Psychiatric Center, 728 N.Y.S.2d 37 (Second Dept., 2001).
70. 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 Alikely to be repeated, it involves a phenomenon which typically evades review, and it implicates substantial and novel issues." Id., at 39.
71. Id., at 42.
72. Id., at 43.
73. Id., at 43, 44 (citations omitted).
74. 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.