# Office of Mental Health

## Oversight of Kendra's Law

Report 2022-S-43 | February 2024

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability

# Audit Highlights

## Objective

To determine whether the Office of Mental Health (OMH) is effectively monitoring Assisted Outpatient Treatment (AOT) to provide reasonable assurance that existing and potential AOT recipients receive their court-ordered treatment. Our audit covered the period from April 2019 to September 2023.

## About the Program

On August 9, 1999, Kendra's Law (Law) was enacted, creating a statutory framework for court-ordered AOT for individuals with severe mental illness who meet criteria outlined in the Law. The Law is reviewed periodically by the Legislature, most recently in 2022.

Implementation of AOT is a joint responsibility and collaboration among OMH, its five regional Field Offices, and local mental health authorities in 57 counties and New York City (we refer to local authorities collectively as local government units or LGUs).

Under the Law, LGUs must timely investigate a referred person's circumstances to determine if the person meets AOT criteria. If so, LGU staff file a petition for AOT with the appropriate court and a hearing is held to review the case and proposed treatment plan. The Law doesn't define "timely," and OMH hasn't developed guidance to use as a benchmark in determining whether investigations are timely.

OMH requires that AOT recipients be escorted home from a hospital discharge or court and be connected with their treatment services through a face-to-face visit within 1 week of the court order. Generally, providers meet with AOT recipients in person weekly after the initial face-to-face meeting. As part of the intensive monitoring and oversight by care management providers to help recipients comply with the terms of their treatment, providers are required to report significant events to their respective LGU within 24 hours of being made aware of them. Significant events are those that may negatively impact a person's AOT, such as being accused of or arrested for committing a crime, becoming incarcerated or homeless, or refusing to take court-ordered medications. LGUs, in turn, must report certain serious significant events, such as weapons possession, sex offenses, domestic violence, and inability to locate an AOT recipient, to the appropriate Field Office to be entered in OMH's Tracking of AOT Cases and Treatments system, or TACT. OMH Central Office and Field Office staff use TACT information to monitor AOT recipients, including identifying circumstances that may affect compliance with their treatment plan and intervening if necessary.

AOT orders generally cover up to 1 year and may be renewed if the LGU determines that the recipient continues to meet AOT criteria after a review that includes an examination by a physician. LGUs must notify their OMH Field Office in writing as to whether they'll pursue renewal. If warranted, within 30 days prior to an order's expiration, LGU staff may petition the court to renew an AOT order. If a recipient no longer meets the criteria, the reason for non-renewal must be reported to OMH.

According to OMH's public statistics on AOT, since the inception of Kendra's Law in 1999 through August 2023, LGUs have conducted nearly 47,000 investigations. Of the 33,847 AOT petitions filed, 32,324 (96%) were granted. New York City is the largest petitioner, accounting for about 20,000 (62%) of the petitions granted. At any given time between 2019 and 2023, there have been an estimated 3,200 to 3,500 individuals under an AOT order.

## Key Findings

OMH needs to improve its oversight in some areas to better ensure that existing and potential AOT recipients receive their court-ordered treatment, as described below.

- We identified instances in which LGUs didn't investigate AOT referrals timely. Using 6 months as a benchmark, we found that 19 of the 41 investigations we reviewed at three LGUs (46%) were not timely and ranged from taking slightly longer than 6 months to nearly 2½ years (198 days and 879 days, respectively).
- We found that most of the AOT recipients whose records we reviewed received their court-ordered treatment timely and in accordance with their treatment plans, but also that OMH doesn't receive information that would allow it to proactively identify delays in the onset of treatment. For example:
  - In one case, the recipient's first face-to-face meeting with their provider was nearly 1 month after their AOT order took effect. The second meeting should have been scheduled for the following week, but wasn't. On the day that the second meeting should have taken place, the recipient was arrested for homicide. It was not until LGU officials reported this information to the Field Office that OMH became aware of the delay in treatment services, investigated the incident and determined that care management providers did not promptly connect with the recipient, and provided guidance to LGU staff and the care management provider.
- We identified problems with the completeness and usefulness of information about significant events and its communication among the parties involved with AOT services. This information may be used to drive decisions that could impact the care and safety of both recipients and the public and plays an important role in overseeing and assessing AOT. For example:
  - For one recipient, case notes indicated that the recipient received psychiatric emergency room or psychiatric inpatient hospital services for suicidal thoughts on 33 separate dates – equivalent to 33 significant events – during the 19-month period between October 2019 and May 2021. However, these events were unreported and, ultimately, this person died by suicide on the same day they were discharged from a hospital visit.
- There were lapses in AOT services for some recipients because LGUs didn't complete reviews of their renewal eligibility as required. For 23 of 37 recipients in our sample (62%), a complete review either wasn't done or potentially wasn't done prior to expiration of their AOT orders, including 17 who weren't examined by a physician and six for whom LGUs didn't document any attempt to examine the recipients before their orders expired. This resulted in expiration of AOT for 11 recipients and temporary lapses for 12 recipients. The lapses in court-ordered services lasted between 34 and 198 days.

## Key Recommendations

- Develop guidance to define "timely" that LGUs and Field Offices can use as a benchmark for completing investigations.
- Evaluate the feasibility of collecting data about the time to connect AOT recipients with their initial services.
- Review and – where considered necessary – clarify existing guidance about significant event reporting to improve:

  - The ability to capture and appropriately share the desired information; and
  - The completeness, accuracy, and comparability of the information reported.
- Improve assurance that LGUs take appropriate action to ensure that AOT orders that are due to expire and should be renewed continue without lapses in treatment and monitoring.

**Office of the New York State Comptroller**
**Division of State Government Accountability**

February 8, 2024

Ann Marie T. Sullivan, M.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Dr. Sullivan:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit entitled *Oversight of Kendra's Law*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

*Division of State Government Accountability*

# Contents

# Glossary of Terms

| Term | Description | Identifier |
|---|---|---|
| OMH | Office of Mental Health | *Auditee* |
| | | |
| AOT | Assisted Outpatient Treatment | *Key Term* |
| Care management providers | Health Home Plus care management services or Assertive Community Treatment (ACT) teams | *Key Term* |
| Field Office | OMH regional field office | *Key Term* |
| Guidance | Guidance for Reporting Significant Events | *Key Term* |
| Law | Kendra's Law, including State Mental Hygiene Law §7.17, §9.47, and §9.60 | *Law* |
| LGU | Local government unit | *Key Term* |
| TACT | Tracking of AOT Cases and Treatments system | *Key Term* |

# Background

On August 9, 1999, Kendra's Law (Law) was enacted, creating a statutory framework for court-ordered Assisted Outpatient Treatment (AOT) to ensure that individuals with severe mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. The Law was named in memory of Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a man with a history of mental illness and hospitalizations. The Law took effect in November 1999 and is reviewed periodically by the Legislature, most recently in 2022.

The specifics of the Law are outlined in the State Mental Hygiene Law, primarily sections 7.17, 9.47, and 9.60. Implementation of AOT is a joint responsibility and collaboration among the Office of Mental Health (OMH), its five regional Field Offices (Field Offices), and local mental health authorities in 57 counties and New York City, collectively referred to as local government units (LGUs). Each LGU is required to have an AOT Program Director and to establish a local AOT program with procedures to implement AOT. OMH monitors and oversees the LGUs and AOT implementation statewide via a Statewide Director of AOT centrally and Program Coordinators appointed at each Field Office.

Under the Law, a person may generally be considered for AOT if they are at least 18 years old and meet the following requirements:

- Be experiencing the effects of a mental illness, be unlikely to survive safely in the community without supervision, need treatment to prevent a relapse or deterioration of their condition that would likely result in harm to the person or others, and be likely to benefit from assisted outpatient treatment;
- Be unlikely to voluntarily participate in outpatient treatment without supervision; and
- Have a history of lack of compliance with treatment for mental illness that has been a significant factor in:
  - Having been hospitalized at least twice within the last 36 months; or
  - One or more acts of serious violent behavior toward self or others within the last 48 months; or
  - The issuance of a court order for AOT that has expired within the last 6 months.

When a potential AOT candidate is identified – most often via a hospital, psychiatric center, or other institution – a referral for investigation is made to the LGU. LGU staff investigate the referred person's circumstances to determine if they meet AOT criteria. If so, staff file a petition for AOT with the appropriate court, after which a physician examines the person and prepares an AOT treatment plan for approval by the LGU and the court. According to the Law, investigations must be completed timely once a referral is made. An order may be granted only if the court finds that AOT is the least restrictive alternative for the person. If an AOT order is granted, the LGU's AOT Program Director is responsible for ensuring each of the categories of treatment included in the order is provided.

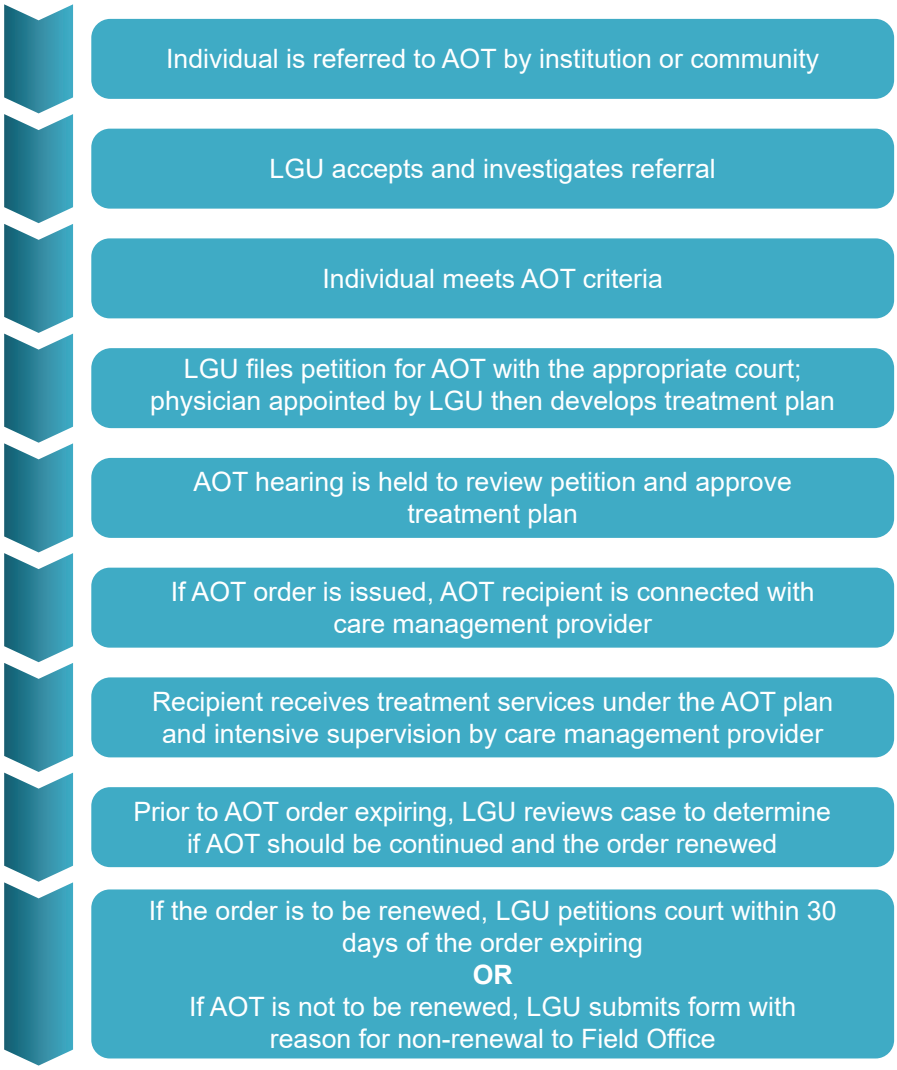
The primary component of AOT is intensive case management provided through Health Home Plus care management services or Assertive Community Treatment (ACT) teams, collectively referred to in this report as care management providers. Both Health Home Plus and ACT serve populations with serious mental illness and directly monitor delivery of services by other providers and the recipient's level of compliance with the order. This includes documenting, among other things, significant events that occur while the recipient is subject to an AOT order. Significant events include, for example, being accused of or arrested for committing a crime, becoming incarcerated or homeless, refusing to take court-ordered medications or participate in other services, or being the victim of a crime. If a recipient doesn't comply with the treatment and this results in a deterioration in their condition, LGU staff may take steps to have the person placed under observation in a hospital for up to 72 hours.

Care management providers routinely report to the LGU AOT Program Directors about each recipient's treatment status, including significant events. LGUs report certain significant events to Field Office Program Coordinators, where they must be entered in OMH's Tracking of AOT Cases and Treatments system (TACT). TACT is the primary data repository for AOT information, including significant events, and is used by OMH Program Coordinators and Central Office officials to review data and monitor behavior patterns and other information of AOT recipients. The Field Office Program Coordinators also do quarterly reviews of a sample of AOT recipient records to help ensure appropriate oversight by both LGUs and care management providers.

AOT orders generally cover up to 1 year and may be renewed if a recipient continues to meet AOT criteria. According to the Law, prior to the expiration of an order, LGU officials must review whether current AOT recipients continue to meet criteria for AOT and determine whether the order should be renewed. As part of this review, the recipient must be examined by a physician. LGUs must notify their OMH Field Office in writing as to whether they'll pursue renewal. If warranted, within 30 days prior to an order's expiration, LGU staff may petition the court to renew an AOT order.

Not all orders are renewed. For example, if a recipient is likely to participate in treatment voluntarily, is deemed able to live safely in the community, or is no longer considered to be experiencing the effects of a mental illness, an order would not be renewed. An order might also not be renewed if the recipient is hospitalized or incarcerated. Between April 1, 2019 and December 20, 2022, 9,141 AOT orders were renewed and 4,248 were not. The top reasons given for non-renewal included AOT no longer being the least restrictive alternative and recipients enrolling in voluntary treatment. Figures 1 and 2 depict the AOT process and related responsibilities.

**Figure 1 - AOT Process**



## Figure 2 - AOT Responsibilities

According to OMH's public statistics on AOT, since the inception of Kendra's Law in 1999 through August 2023, LGUs have conducted nearly 47,000 investigations. Of the 33,847 AOT petitions filed, 32,324 (96%) were granted. New York City is the largest petitioner, accounting for about 20,000 (62%) of the petitions granted. At any given time between 2019 and 2023, there have been an estimated 3,200 to 3,500 individuals under an AOT order. According to a 2023 report from the Treatment Advocacy Center, all but three U.S. states – Connecticut, Maryland, and Massachusetts – have laws that authorize a form of AOT.

Ensuring that people with mental illness get care to prevent or mitigate harm to themselves or others in the community continues to be a pressing issue. In January 2020, 21 years after Kendra Webdale's death, Michelle Go was similarly pushed to her death in front of a New York City subway train by a mentally ill person. This incident prompted City and State officials to call for extending Kendra's Law and in April 2022, it was extended through 2027. The Law was also amended to allow recipients to be considered for a new AOT order up to 6 months after their order expired. This can occur if the person experiences a substantial increase in mental illness symptoms that interfere with their major life activities, as determined by the LGU previously responsible for monitoring their court order. OMH's oversight role is a key part of AOT, which continues to be an important tool for providing enhanced supervision to allow recipients to live safely in their communities.

# Audit Findings and Recommendations

We found that OMH needs to improve its monitoring and oversight to better ensure that existing and potential AOT recipients receive their court-ordered treatment. Areas we identified for improvement include length of AOT investigations and related information-sharing, initiation of AOT services, the quality of information about significant events and how that information is shared, as well as lapsing AOT orders. Our findings resulted in six recommendations to address these areas.

## AOT Investigations

We identified instances in which LGUs didn't investigate AOT referrals timely. We also found cases in which LGU staff didn't report investigation information to the Field Offices as required, and instances in which Field Offices didn't report that same information to the OMH Central Office.

### Long Investigation Times

When a person is first referred for consideration for an AOT order, the LGU must investigate their circumstances to determine if the person meets AOT criteria. LGUs are responsible for conducting the investigations timely and documenting each investigation's initiation, completion, and disposition dates. Under the Law, Field Offices are required to ensure that LGUs establish procedures to ensure that these referrals are investigated in a timely manner. Though the Law requires that investigations be completed "timely," it doesn't define the term. Further, OMH hasn't developed guidance, such as time ranges, for LGUs to use as a benchmark for their investigations.

In the absence of such a benchmark, we considered an investigation to be timely if it was completed within 6 months or, if not, if there was evidence that LGUs were making regular progress on the investigation based on our review of case notes. Using these criteria, we found that 19 of the 41 investigations we reviewed at three LGUs (46%) were not timely and ranged from taking slightly longer than 6 months to nearly 2½ years (198 days and 879 days, respectively).

For example, in one instance, an investigation into a high-risk individual who had demonstrated themselves to be a danger to others lasted 663 days before it was ultimately closed – without pursuing AOT – due to the length of the investigation and not having received records requested through a subpoena. According to referral documentation, the person had barricaded themselves in their home and threatened a family member with a knife as a result of hallucinations. Police responded and removed a firearm from the person's home. Upon receiving the referral, LGU staff subpoenaed medical records, but didn't receive them and didn't follow up on the request. They also didn't maintain any notes during the investigation period.

In another case involving the same LGU, the initial referral documentation for a person cited multiple hospitalizations, non-compliance with medication, and suicidal intentions. LGU staff promptly requested and received the medical records necessary to complete the investigation. However, they didn't schedule an examination until a year after receiving the records, which left the person without an

AOT determination and potentially important services during this time. LGU officials explained that an oversight in this instance led to the long investigation period. In response to our observations, LGU officials agreed that these investigations took longer than they should have and that different actions should have been taken to further their progress or bring them to a close.

We also found long investigation times for high-risk individuals at the other two LGUs whose investigation records we reviewed. In one case, an LGU documented the on-again, off-again progress of an investigation that showed several multiple-month gaps. The investigation ultimately took about 2 years (742 days), during which time the individual was hospitalized on five occasions, including once after assaulting someone. LGU officials eventually pursued AOT for this person at the conclusion of the investigation.

In addition, officials at three of four LGUs we visited said that they don't monitor the timeliness of investigations and haven't developed procedures to do so, despite the Law's requirement. The fourth LGU had developed procedures to ensure that investigations are completed within certain time frames, yet we still found instances of long gaps in the investigation progress.

In response to our findings, OMH officials cited factors that add significant time to the investigation process, including obtaining records through a subpoena (in the absence of the referred person's authorized release of this information) and lack of a regular residence for the person. We believe that another contributing factor is the lack of established procedures at the LGUs to guide investigation timeliness. Given the potential for high-risk behavior by those referred to AOT, OMH must do more to ensure that investigations make reasonable progress while they're open. OMH officials agreed to explore defining a reasonable time frame for LGUs and Field Offices to use as a benchmark. In addition, they indicated that they'll develop a process for reporting delays beyond the benchmark to the relevant Field Office.

## Gaps in Reporting Investigation Information

We identified communication deficiencies at the LGU and Field Office level that diminish the reliability of AOT investigation information available to OMH. Under the Law, LGUs must provide written notice to their respective Field Office when they complete an investigation. In addition, in May 2019, OMH developed a Timely Investigation Form that LGU staff can, but are not required to, use to report information that is required by the Law to Field Offices, such as beginning and ending dates of the investigation and its disposition. Field Office staff, in turn, must compile this information and share it with the OMH Central Office, where it's intended to help monitor investigation times across regions and statewide.

Of the four LGUs we visited, three reported information on completed investigations to Field Offices as required; the other LGU didn't. Of the five OMH Field Offices, one provided this information to the Central Office, two didn't, and two reported incomplete information (e.g., the data was missing certain periods of time). In addition to the above limitations, because the information reported represents only

investigations that are complete, in line with the statutory requirement, neither the Field Offices nor OMH can use it to assess the status of investigations that are ongoing. According to OMH officials, Field Offices have experienced delays in the data collection process. They also said that they're in the process of creating an electronic method that LGUs will use to enter investigation information directly so it can be reported to and monitored by OMH.

## Recommendations

1. Develop guidance to define "timely" that LGUs and Field Offices can use as a benchmark for completing investigations and ensure that LGUs establish procedures to investigate AOT referrals in a timely manner, as required under the Law.
2. Improve assurance that Field Offices obtain and compile the required investigation data from LGUs and provide timely investigation reports to OMH's Central Office.

## Establishing AOT Services

We found that most of the AOT recipients whose records we reviewed began their court-ordered treatment promptly and in accordance with their treatment plans, but also that OMH doesn't receive information that would allow it to proactively identify delays in the onset of treatment.

To be considered for AOT, a person must be experiencing the effects of a mental illness and be unlikely to survive safely in the community. Because of the safety concern, it's important that recipients begin their court-ordered AOT as soon as possible. According to OMH officials, they require that AOT recipients be escorted home from a hospital discharge or court and be connected with their treatment services through a face-to-face visit within 1 week of the court order. Generally, providers meet with AOT recipients in person weekly after the initial face-to-face meeting.

Day-to-day oversight of AOT recipients lies with care management providers, who, according to OMH Program Standards, are expected to have contact with LGU personnel at least weekly regarding a recipient's compliance with treatment. OMH Field Offices are responsible for ensuring that a recipient receives the treatment in the court-ordered plan and that the treatment is provided in a timely manner (which can vary depending on the treatment plan). If services are not delivered timely, Field Offices must require LGU staff to take corrective action.

Of the 46 AOT recipients' records we reviewed, 44 (96%) recipients received timely services and two experienced delays in starting treatment after their court orders began. In one case, the care management provider didn't meet with the AOT recipient until nearly 2 months after their AOT order took effect. In the other, the AOT recipient's first face-to-face meeting with their provider was nearly 1 month after their AOT order took effect. The second meeting should have been scheduled for the

following week, but wasn't. On the day that the second meeting should have taken place, the recipient was arrested for homicide. It was not until LGU officials reported this information to the Field Office that OMH became aware of the delay in treatment services, investigated the incident and determined that care management providers did not promptly connect with the recipient, and provided guidance to LGU staff and the care management provider.

Under OMH's AOT Service Verification Procedures, Field Office staff review a sample of each of the five OMH regions' AOT caseloads each quarter to determine whether recipients are getting appropriate treatment and report the results to OMH Central Office. These reviews include, for example, reviewing medical charts and service provider interviews, verifying weekly contact between providers and recipients, and reviewing drug screenings and records of search efforts for missing people. If Field Office staff identify egregious findings, such as failure to provide the minimum face-to-face contacts required under the treatment plan, they may require a corrective action plan, with subsequent follow-up.

However, the quarterly reviews don't give OMH timely insight about the time that elapses between the AOT order and when a recipient begins treatment. While the established process allows the Field Offices to regularly monitor whether recipients receive treatment and can detect patterns of non-compliance or areas for improvement in documenting case management, it is a retroactive solution and doesn't allow OMH to detect delays in receiving initial treatment services that may occur.

In response to our findings, OMH officials said they'll consider the feasibility of collecting additional data points from LGUs and providers – such as date of initial contact – for analysis across the population.

## Recommendation

3. Evaluate the feasibility of collecting data about the time to connect AOT recipients with their initial services and – if found to be feasible – collect and use the data for decision making.

## Significant Event Reporting

Information about significant events that affect AOT recipients may be used to drive decisions that could impact the care and safety of both recipients and the public and plays an important role in overseeing and assessing AOT. We identified problems with the completeness and usefulness of information about significant events and its communication among the parties involved with AOT services.

People subject to AOT orders receive intensive monitoring and oversight by care management providers to help ensure they comply with the terms of their treatment. As part of this monitoring, providers are required to report significant events to the LGUs and to follow OMH's two-page Guidance for Reporting Significant Events (Guidance). Significant events are those that may negatively impact a person's AOT,

such as being accused of or arrested for committing a crime, becoming incarcerated or homeless, refusing to take court-ordered medications or participate in other court-ordered services, or being the victim of a crime. Providers must report these events to their respective LGU within 24 hours of being made aware of them.

Certain significant events, which are denoted by an asterisk in the Guidance, must also be reported by LGUs to the Field Office to be entered in TACT. These events include kidnapping, weapons possession, sex offenses, domestic violence, inability to be located, and attempted suicide. Because the Guidance document includes checkboxes to indicate the type of event and a field for a narrative description of the incident – including the date the care management provider became aware of the event and the AOT recipient's stated reasons for non-compliance – providers and LGU staff may use it as a form to report significant events. Because they're not required to use it, however, there are different ways this information is reported to LGUs and Field Offices.

Adequate internal controls include having reliable and timely information that's adequately preserved, especially if it's used for decision making. Neither LGUs nor care management providers have access to TACT. OMH Central Office and Field Office staff, however, use TACT information to monitor AOT recipients, including identifying circumstances that may affect compliance with their treatment plan and intervening if necessary. It's also an important tool for OMH to evaluate whether it is achieving key objectives and addressing risks associated with its oversight role in Kendra's Law. As such, the information in TACT must be reliable.

## Completeness and Quality of Significant Event Information

We reviewed case files for a sample of 46 of the 8,071 individuals who were under court-ordered AOT at some point between April 1, 2019 and December 20, 2022. We determined that, of the 550 significant events reported in TACT for 43 recipients in our sample, there were data entry issues with 123 events (22%, representing 27 recipients).

We also found that providers didn't report an additional 47 significant events, which were recorded in the recipients' case records, to three LGUs. The events, related to seven recipients, included those that were both reportable and not reportable in TACT, and included recipients who were hospitalized, missing, or missing court-ordered medications or had removal orders. In one noteworthy example, case notes indicated that a recipient received psychiatric emergency room or psychiatric inpatient hospital services for suicidal thoughts on 33 separate dates – equivalent to 33 significant events – during the 19-month period between October 2019 and May 2021. However, these events were unreported and, ultimately, this person died by suicide on the same day they were discharged from a hospital visit.

We compared TACT data with case records at four LGUs and found 112 significant events, representing 28 AOT recipients, that should have been reported in TACT,

but weren't, due to either the LGU not reporting them to the Field Office or the Field Office not entering them. The severity of these missing events varied and included instances of serious threats of self-harm or harm to others, medication refusal that resulted in a removal order, and inability to be located.

We also identified TACT data entry errors with 123 of the 550 significant events (representing 27 and 43 recipients, respectively), which included 98 events for 19 recipients that were entered without descriptions of the events (though they were available). For the other 25 events (13 recipients, some with more than one type of error), there were incorrect dates of events or inaccurate types of events (e.g., case records cited an arrest vs. serious non-compliance with court-ordered services entry in TACT).

In addition, there was a lack of understanding at one of the four LGUs we visited about which events need to be reported to the Field Office. In this case, staff reported all, or nearly all, significant events, including those not required to be reported. This resulted in Field Office staff having to determine what should or shouldn't be entered in TACT. In response to our preliminary findings, OMH officials cited system limitations and security issues with TACT that prevent them from expanding access to LGUs. However, they also indicated that they're in the process of updating the significant event reporting process with the goal of a separate portal where LGUs can enter data directly.

Finally, we note that OMH's Guidance was last revised in 2014, and that some events that aren't currently required to be entered in TACT may provide valuable insight for OMH. We found 91 significant events in 24 of 46 recipients' case files that, while not required to be reported to the Field Office and entered in TACT, were serious and affected the AOT recipient and/or the community. For example, one recipient was arrested for harassment and petit larceny and later jailed, but arrests, although reportable to the LGU, are not required to be entered in TACT unless they're serious. Other examples of significant events not required to be reported in TACT include when a recipient is receiving psychiatric care from an emergency room or psychiatric inpatient hospital, as was the case in the prior example in which the recipient had 33 psychiatric events. In responding to our observations, OMH officials said they were discussing whether the revisions to the reporting process would include expanding reportable incidents.

## Recommendation

4. Review and – where considered necessary – clarify existing guidance about significant event reporting to improve:
    - The ability to capture and appropriately share the desired information; and
    - The completeness, accuracy, and comparability of the information reported.

# AOT Order Renewals

There were lapses in AOT services for some recipients because LGUs didn't complete reviews of their renewal eligibility as required. We also found problems with identifying and reporting reasons for non-renewal that reduced the value of this information.

## Lapsing AOT Orders

We identified instances in which LGU staff did not complete reviews of recipients' AOT renewal eligibility or document what had been done to review AOT orders before they expired. Using data from TACT, as well as other petition information, we identified AOT recipients with orders that expired, potentially without a complete review. We reviewed supporting documentation from April 2019 to October 2022 for a sample of 37 recipients at three LGUs, and determined that for 23 (62%) of the 37 recipients a complete review either wasn't done or potentially wasn't done prior to expiration of their AOT orders, as required. In 17 cases, the recipients weren't examined by a physician; and in six cases, LGUs didn't document any attempt to examine the recipients before their orders expired. This resulted in expiration of AOT for 11 recipients and temporary lapses in AOT for 12 recipients. The lapses in court-ordered services lasted between 34 and 198 days.

For example, officials at one LGU scheduled a renewal examination just 1 week prior to a recipient's AOT order expiring. The LGU did not document any attempt to complete the examination, and the order expired. Prior to the order expiring, the recipient's treatment provider recommended that drug treatment be added to the treatment plan upon renewal of the order. After AOT lapsed, the recipient was displaced from their homeless shelter for testing positive for narcotics, an outcome that may have been potentially avoided if the recipient had been examined prior to their order expiring. In another case, there was no evidence that the LGU attempted to schedule a pre-expiration examination for a recipient who – before the order expired – had exhibited disturbing behavior and was hospitalized under a removal order for having delusions. During the lapse in AOT, the recipient was hospitalized again and was reportedly aggressive toward hospital staff. In both of these cases, the recipients eventually received new court orders for AOT, suggesting that, had the renewal examinations occurred prior to expiration, the lapses in AOT could have been avoided.

We also found instances in which LGUs didn't pursue available resources, such as a court order to have recipients transported to their examination after they had repeatedly missed scheduled exams that were necessary to renew their AOT orders. One of the four LGUs we visited had a policy to pursue such a court order after a recipient repeatedly missed exams. In response to our findings, OMH officials cited the logistical considerations that make using court orders difficult in some circumstances, including whether a recipient could be located and coordinating doctor and hospital schedules to do the exams within the time allowed by the order. They also said that the LGUs should be reminded about their ability under the Law to

seek renewals without the examination when they can demonstrate efforts to get the recipient to court. OMH must make efforts to ensure that LGUs are taking available actions to ensure that AOT orders that are due to expire and should be renewed continue without lapses in treatment and monitoring.

## Reasons for Non-Renewal

If LGU staff decide not to renew a person's AOT order, they must complete the "Determination of AOT Non-Renewal" form (non-renewal form), indicating whether the person still meets AOT criteria and the reasons for non-renewal, and submit it to the Field Office prior to the order's expiration. For example, a recipient may be judged to meet all of the AOT criteria but not be renewed because they cannot be located or are incarcerated or hospitalized. In other cases, a recipient may not be renewed because they are deemed likely to voluntarily participate in treatment or no longer need the court-ordered treatment to live safely in the community.

We identified instances in which LGU staff used the "Other" category to report reasons for non-renewals when more specific descriptions – such as "missing" or "deceased" – were available and accurate for the situation. Based on data in TACT, "Other" was used 567 times (10% of the 5,656 entries between April 2019 and February 2023) and was the third most common reason reported for non-renewals, after AOT no longer being the least restrictive treatment and recipients being enrolled in voluntary treatment. Excessive use of "Other" diminishes the quality of the resulting information and may compromise its value for understanding and analyzing the reasons for non-renewal. In response to our observations, OMH officials said that some LGU staff expressed confusion about how to properly use the non-renewal form.

# Recommendations

5. Improve assurance that LGUs take appropriate action to ensure that AOT orders that are due to expire and should be renewed continue without lapses in treatment and monitoring.
6. Provide guidance to LGUs about how to appropriately report reasons for AOT non-renewal.

# Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether OMH is effectively monitoring AOT to provide reasonable assurance that existing and potential AOT recipients receive their court-ordered treatment. Our audit covered the period from April 2019 to September 2023.

To accomplish our objective and assess related internal controls, we reviewed relevant sections of the State Mental Hygiene Law and OMH policies and procedures, interviewed OMH and Field Office officials and employees, observed certain OMH processes, and examined OMH records. We also interviewed LGU officials, reviewed LGU reports, and reviewed AOT recipient case files.

We used a non-statistical sampling approach to provide conclusions on our audit objective and to test internal controls and compliance. Because we used non-statistical sampling, we cannot project the results of each sample to the respective populations. To review oversight of AOT, we judgmentally selected a sample of four of 58 LGUs that administer AOT based on number of AOT recipients, availability of data, and number of significant events. Our samples, which are discussed in detail in the body of our report, were as follows:

- A judgmental sample of 46 of the 8,071 individuals under court-ordered AOT at some point between April 1, 2019 and December 20, 2022, based on number of significant events, number of petitions filed, amount of time between petition filing and AOT taking effect, and reasons for non-renewal, to assess whether each AOT recipient received timely services prescribed in their treatment plans. We selected a judgmental sample of 218 of 550 significant events for the 46 recipients and reviewed case notes for the weeks surrounding these events. We selected significant events based on type of event, focusing on those that indicated violence, hospitalizations, removal orders, and events that may have indicated a danger to the recipient or others.
- A judgmental sample of 41 of 5,454 active investigations between April 1, 2019 and February 9, 2023, based on the length of the investigation, to assess the LGUs' timeliness in completing those investigations.
- A judgmental sample of 37 of 4,344 court orders not renewed between April 1, 2019 and February 17, 2023, based on reasons for non-renewal and whether there was more than one court order filed within 1 year of a previously expired order. We used this sample to assess LGUs' reviews of AOT orders that were set to expire.

We obtained data from TACT and from OMH's Timely Investigation Data spreadsheets. We assessed the reliability of that data by reviewing existing information, interviewing officials who were knowledgeable about each system, and tracing to and from source data. We determined that the data from these systems was sufficiently reliable for the purposes of this report.

# Statutory Requirements

## Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of OMH's oversight of Kendra's Law.

## Reporting Requirements

We provided a draft copy of this report to OMH officials for their review and formal written comment. We considered their response in preparing this final report and have included it in its entirety at the end of the report. In their response, OMH officials generally agreed with our recommendations and described actions that are already underway or that are planned to address them. We address one aspect of their response in a State Comptroller's Comment.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

# Agency Comments

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MOIRA TASHJIAN, MPA
Executive Deputy Commissioner

January 25, 2024

Heather Pratt, CFE
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Heather Pratt:

In accordance with Executive Law § 170, the following are the responses from the Office of Mental Health (OMH) to the Office of the State Comptroller's (OSC's) draft audit report entitled, "*Oversight of Kendra's Law"* (2022-S-43).

OMH generally agrees with OSC's findings and recommendations; however, we would like to provide additional context and clarity on OMH's oversight of assisted outpatient treatment (AOT) as a whole.

As OSC notes, Kendra's Law, Mental Hygiene Law (MHL) §9.60, was enacted on August 9, 1999, creating a statutory framework for court-ordered treatment to ensure that individuals with mental illness and a history of hospitalizations or violence participate in community-based services appropriate to their needs. 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. Since these individuals are not voluntarily receiving services, effective service provision and monitoring may be more challenging.

For this reason, a cohesive local, county and statewide system was established under MHL §9.48 which requires local government units (LGU's) to report to the state on a variety of matters relating to the AOT process and individuals subject to an AOT order, including: investigations, evaluations, court orders and the progress of AOT recipients who are in their counties. To be effective, localities and providers may need to tailor their services to meet the individuals' unique needs. Kendra's Law allows an individual to live a life as independently as possible in their local community, through intensive coordination of key services including behavioral health services and housing. Kendra's Law is an important tool for Local Government Units (LGUs) to consider amongst an array of other services and degrees of need in the communities they serve.

It is also important to note that OMH's oversight of AOT has been impacted by the statute's limited reporting requirements for LGU's. As detailed in our responses to OSC's recommendations, OMH will explore ways to obtain additional information for enhanced monitoring.

OMH would also like to point out that OSC's sample was not representative of the AOT population as it focused on the most challenging individuals on AOT. While OMH does not disagree with OSC's sampling methodology, an analysis of the data provided some additional insight.

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We reviewed the number of significant events for the entire population of active individuals on AOT between April 1, 2019 and December 23, 2022[1] and found that 69 percent (5,484 of the 7,971 individuals) did not have any significant events reported in the Tracking of AOT Cases and Treatments system (TACT). Conversely, OSC's sample included only 9 percent (4 of the 46 individuals) who did not have any significant events reported in TACT. Similarly, the average number of significant events per recipient was 1 for the entire population of active individuals on AOT, significantly lower than the sample used by OSC which was 11 per individual. As such, OSCs selected sample clearly included a higher proportion of cases with more significant events.

Comment 1

Lastly, OMH would like to clarify and emphasize that its regional field offices are part of OMH central office. Figure-2 on page 10 of the report may incorrectly give the impression that the two are separate entities. OMH (which is comprised of the Office of Statewide AOT implementation and the program coordinators at the regional field offices) is responsible for statewide oversight and monitoring of the AOT program. While the roles of the AOT program coordinators are specifically outlined in MHL §7.17(f), these individuals are still part of OMH central office, and all staff work together to provide the required oversight of AOT implementation.

*AOT Investigations*

It is important to note that there are several factors that can affect the timeframe on investigations which are beyond the control of the LGU.

Prior to 2011, MHL §33.13 allowed petitioning LGU's to be able to obtain medical records in the course of their AOT investigation even if the individual was not consenting or did not know that their records were being released. In 2011, a court decision was made in the *Matter of Miguel M.*[2] that changed the way in which petitioners could obtain records. The Court of Appeals found that records used to support proceedings to compel treatment must either be received through an authorized release signed by the respondent or via a court ordered subpoena, which required the individual to be put on notice of the court hearing and be provided with an opportunity to be heard. The requirement to obtain court ordered subpoenas added significant time to the investigation process as most of the individuals who are under investigation do not consent to the release of their records and a court order needs to be obtained. This places the timing of the first part of the investigation into the hands of the court system.

As OSC alludes to in the report, other factors that increase the investigation time include instances where an individual lacks a regular domicile, and when individuals in New York City move between boroughs which can make them difficult to locate. Additionally, it is not uncommon for individuals who are currently under investigation to circulate in and out of local hospitals or jails, which can prolong the investigation and decision-making process.

Lastly, the scope of OSC's audit was April 1, 2019 through September 2023 which included the three-year period of the federally declared public health emergency. During this time, the New York City court system was prioritizing cases and court ordered subpoenas, including those involving medical records for AOT petitions, were not the primary concern. During COVID, face-to-face engagement rates dropped and hospital beds that were utilized for mental health needs were re-allocated for patients with medical needs. Overall, there were scarce emergency resources for evaluating individuals and enacting removals issued pursuant to MHL §9.60.

[1] We used the list of AOT recipients that were provided to OSC on this date.
[2] Matter of Miguel M., 17 N.Y.3d 37 (2011)

*Establishing AOT Services*

Within this section of the report OSC describes the oversight responsibilities of the care manager, LGU, and OMH regarding their roles in ensuring that court-ordered treatment was provided promptly and in accordance with the individual's treatment plan. OSC states on page 14 of the report:

> "OMH Field Offices are responsible for ensuring that a recipient receives the treatment in in the court-ordered plan and that the treatment is provided in a timely manner (which can vary depending on the treatment plan).

While MHL §9.60 does state that program coordinators (i.e., OMH field office staff) are responsible for the oversight and monitoring of AOT programs, it is important to note that according to MHL §9.48 directors of community services of a LGU (or a director of a hospital which operates, directs, and supervises an AOT program) must provide written reports to the program coordinators and ensure the timely delivery of services as required by the order. The LGU is the first layer of oversight for the timely delivery of services, and it is incumbent on OMH to review reports received to verify such timeliness.

OMH's responses to the recommendations are as follows:

**OSC Recommendation 1:** Develop guidance to define "timely" that LGUs and Field Offices can use as a benchmark for completing investigations and ensure that LGUs establish procedures to investigation AOT referrals in a timely manner, as required under the Law.

**OMH 30-Day Response:** OMH agrees with this recommendation and will define a reasonable time frame to use as a benchmark. Within the first six months of 2024, OMH will develop a work group (which will include the Conference of Local Mental Hygiene Directors) to identify a reasonable time frame for the investigation period and obtain input on an appropriate reporting mechanism. This will facilitate OMH's oversight capacity to monitor and make recommendations for delayed investigations. Once a process is developed, OMH will provide guidance to the LGUs and internally to its regional field offices regarding documentation expectations during the investigation period.

**OSC Recommendation 2:** Improve assurance that Field Offices obtain and compile the required investigation data from LGUs and provide timely investigation reports to OMH's Central Office.

**OMH 30-Day Response:** Through the establishment of a timeliness benchmark (see response to recommendation 1), OMH will expand on existing guidance and include information related to OMH review (by both the regional field offices and Office of Statewide AOT Implementation) of the reported investigation data.

**OSC Recommendation 3:** Evaluate the feasibility of collecting data about the time to connect AOT recipients with their initial services and – if found to be feasible – collect and use the data for decision making.

**OMH 30-Day Response:** OMH will evaluate the feasibility of collecting additional data points from providers and LGUs (e.g., date of initial contact) so that data can be analyzed across the population. This effort may include the development of new data collection systems and corresponding procedures if deemed necessary.

**OSC Recommendation 4:** Review and – where considered necessary – clarify existing guidance about significant event reporting to improve:

- The ability to capture and appropriately share the desired information; and
- The completeness, accuracy, and comparability of the information reported.

**OMH 30-Day Response:** OMH is in the process of reviewing and modifying the existing significant event reporting form with the intent of expanding the level of detail required and appropriately sharing the information when needed. Guidance will be updated or created as appropriate based on this review.

**OSC Recommendation 5:** Improve assurance that LGUs take appropriate action to ensure that AOT orders that are due to expire and should be renewed continue without lapses in treatment and monitoring.

**OMH 30-Day Response:** OMH has guidance in place that recommends LGU's, who are the official direct oversight entity for local AOT services, review whether individuals under AOT orders continue to meet the criteria prior to thirty days before the current order expires. Additionally, AOT Service Verifications conducted by OMH field office staff document whether these reviews occur in the summaries provided to LGU's. OMH is in the process of developing training materials for order renewals with an anticipated rollout to the LGUs in calendar year 2024.

**OSC Recommendation 6:** Provide guidance to LGUs about how to appropriately report reasons for AOT non-renewal.

**OMH 30-Day Response:** OMH agrees with this recommendation and will develop training for the county AOT staff which will include the use of a non-renewal form. OMH anticipates conducting a training for each region in calendar year 2024.

Please let us know if you have any questions or require additional information concerning the above.

Sincerely,

Moira Tashjian
Executive Deputy Commissioner

# State Comptroller's Comment

1. As stated on page 20 of our report, we used non-statistical, judgmental sampling. We also stated that we cannot project the results of those samples to their respective populations. As such, we believe that we've adequately described our selection methodology and any limitations of the resulting conclusions.

# Contributors to Report

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