Fiscal impact reports (FIRs) are prepared by the Legislative Finance Committee (LFC) for standing finance committees of the NM Legislature. The LFC does not assume responsibility for the accuracy of these reports if they are used for other purposes.

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F I S C A L   I M P A C T   R E P O R T

SPONSOR Pacheco **ORIGINAL DATE** 1/29/16 **LAST UPDATED** **HB** 198

SHORT TITLE Assisted Outpatient Treatment Act **SB**

ANALYST Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	*Indeterminate	*Indeterminate	*Indeterminate	*Indeterminate	Recurring	General Fund

*Reference is made to AOC and HSD concerns in Fiscal Implications.

Relates to Appropriation in the General Appropriation Act
House Bill 198 is similar to Senate Bill 113

SOURCES OF INFORMATION

Responses Received From
Administrative Office of the Courts (AOC)
Attorney General's Office (AGO)
New Mexico Corrections Department (NMCD)

SUMMARY

Synopsis of Bill

House Bill 198, modeled after Kendra's Law in New York State, creates the authority for a district court judge in New Mexico to order people diagnosed with mental illnesses who meet certain criterion into mandatory "Assisted Outpatient Treatment" programs for up to one year. "Assisted Outpatient Treatment" is defined by the bill as categories of outpatient treatment ordered by a district court which include: case management or assertive community treatment services; medication; periodic blood tests or urinalysis; individual or group therapy; and day or partial day programming activities etc.

The bill defines terms such as "advance directive for mental health treatment", "assertive community treatment" and "assisted outpatient treatment." Additionally the bill develops criteria for when a person may be ordered by a court to participate in assisted outpatient treatment. Criteria include: having a primary diagnosis of mental disorder, having a history of a lack of compliance with treatment for a mental disorder, and unwilling or unlikely to participate

voluntarily in outpatient treatment.

The bill allows for a petition for assisted outpatient treatment by relatives and others, criteria for the petition to be filed, and requirements for qualified professionals to examine the patient. The bill allows for a party or the respondent's surrogate to apply to stay, vacate, modify, or enforce an order.

The bill provides for treatment proceedings, sequestration, and confidentiality of records. The bill provides criteria for a hearing and when the hearing can be held after an examination by a qualified professional.

The bill requires a written proposed treatment plan to accompany the petition, to be developed by a qualified professional, which states all treatment services recommended for the respondent with specifications regarding who will provide each service. The bill provides for additional written proposed treatment plan requirements such as case management services or an assertive community treatment team to provide care coordination and assisted outpatient treatment services.

Additionally, the court order for assisted outpatient treatment is required to: not exceed one year, specify the services respondent is to receive, and direct service providers to provide or arrange for all assisted outpatient treatment throughout the period of the order. Nothing in the court order shall require payment, not otherwise a covered benefit, by health maintenance organizations, managed healthcare plans, health insurance companies, group health plans, or the state Medicaid program.

FISCAL IMPLICATIONS

For similar 2015 legislation (SB53) HSD observed that the bill:

- Does not make appropriations to cover the cost of court-ordered services and is silent as to who would be responsible for the cost. Insurance or Medicaid may reimburse providers for some of the services, but the individual could still be responsible for the non-covered services (e.g. supervision of living arrangements) and any co-pays or deductibles.

- Services discussed in Section 7 related to treatment planning may not be either billable or medically or clinically necessary services reimbursable by existing fund sources. Many of the services listed as the types of services that can be court-ordered may be covered by Medicaid for those individuals that are enrolled.

The following budget information was provided by Bexar County, Texas, with identifiable costs to a program that is comparable to the program discussed in this bill. The budget is for year one of the program,

Table: Bexar County Assisted Outpatient Treatment Program-Judge Oscar Kazem

Position	FTE	Salary and Benefits
Psychiatrist	.5	$126,190
RN	1.0	$76,975
Court Liaison	1.0	$50,372
BSW Discharge Caseworker	1.0	$42,904
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Clinical Practitioner (caseload 1:18)	1.0	$50,372
Total Year One Estimated Budget		**$548,301**

AOT census: 90
Average cost per respondent: $6,092

The following information was received from Judge Oscar Kazen of Bexar County Texas.
After studying 100 participants there was a combined lifetime bed utilization of 67,301.

In the year prior to the court order

- Total admission for the year prior to the court order: 164
- Total bed day utilizations: 8,873

During the year of the court order

- Total admissions during the year of court order: 61
- Total bed day utilizations: 4,577

During the year after the court order expired

- Total admission after completion of the court order: 38
- Total bed day utilizations: 3,418

Agnes Zacarias, LPC, NCC is the Clinical Programs Director, Mental Health Outpatient and Specialty Court Programs for the Texas AOT program reports that a snapshot of 10 clients the hospital saved approximately $1.3 to $1.4 million in state hospital bed day dollars.

A New York State AOT program evaluation of June 30, 2009 notes that the probability of hospital admission was reduced from 14% to 11% per month during the first six months of AOT and to 9% during the 7 to 12 month period of AOT. Another evaluation published in the American Journal of Psychiatry (2013) noted significant net cost decreases of 43% in the first year and an additional 13% in the second year in the New York program.

These reports provide positive outcome data for the respective AOT programs and should be taken into account. However, information on program structure was not addressed and this is being noted.

It should be noted that UNM commented on the similar 2015 legislation that the implementation of Assisted Outpatient Treatment (AOT) would require dedicated resources from providers to assure access to needed services and compliance with treatment plans as mandated.

UNM noted that in Pima County Arizona (Tucson), which has extensive experience with AOT and a well-developed system of care, there are currently around 600 patients annually managed under this status. The number of patients in need of AOT services could approach this number over the long-term in Bernalillo County. However, unlike Arizona's law, this legislation would require more specific criteria for ordering AOT that could impact the number of people managed through this approach.

UNM suggested that in order to manage this population in Bernalillo County a dedicated treatment team consisting of community support workers, peer specialists, therapists, nursing and physician services be developed. In addition, it would be important for the team to have other resources that would allow for mobile crisis response for patients similar to those found with Assertive Community Treatment (ACT).

The following estimated budget was provided by UNM. The budget is for year one of the program, assumes a phased in AOT population with a maximum of 300 patients in year one. This model would need to be scaled going forward to account for growth in the program.

Table: Estimated Budget for Bernalillo County

Position	FTE	Salary and Benefits
Community Support Worker	10.0	$550,368
Peer Specialist	4.0	$165,739
Clinical Counselor/Clinical Social Worker	4.0	$282,522
Psychiatric RN	3.0	$238,309
Advanced Practice Provider (NP)	1.0	$126,000
Physician Provider	.25	$62,500
Total Staffing	22.25	**$1,425,438**
Vehicles and Fuel Year One (3 vehicles)		$67,200
Computers/Other Supplies/ Other Expenses		$106,000
Total Year One Estimated Budget		**$1,598,638**

AOT census: 300

Average cost per respondent (excluding vehicles and computers): $4,751

However, the intention of this legislation is not to provide for a dedicated treatment team for this program. The legislation establishes court proceeding for the AOT program to be supported by current treatment providers. Therefore, the Bexar County budget has been provided as an alternative.

If the bill results in fewer individuals sentenced to prison there may be savings to the state. According to the New Mexico Corrections Department (NMCD), the average cost per day to house an inmate in a state prison is $123, or about $45,250 per year. However, costs can range from as high as $148 per day, or $54,020 per year, to a low of $80 per day, or $29,200 per year, depending on which prison offenders are placed in. A longer length of stay would increase the cost to house the offender in prison. In addition, sentencing enhancements could contribute to overall population growth as increased sentence lengths decrease releases relative to the rate of admissions. The NMCD general fund budget, not including supplemental appropriations, has grown $5 million, or 7 percent, since FY11 as a result of growing prison population.

Court-ordered assisted outpatient treatment for certain probationers and parolees could help prevent these individuals from committing new crimes or otherwise violating their supervision conditions, preventing these individuals from having to be revoked by the Parole Board or sentencing judge and sent back to prison for violating their supervision conditions.

Additionally, the New York State evaluation indicates that arrests in any given month were reduced from 3.7 % to 1.9%, which supports the above statement.

In an attachment AOC, provided an in-depth analysis. A summary of the analysis follows:

> The AOC is in the process of determining potential fiscal implications associated with the proposed legislation, including the cost of contracting for attorney services potentially required by the AOT, as well as personnel costs, training and education costs, data compilation and reporting costs, and other associated costs. Although the bill permits AOT only where a municipality or county has entered into an MOU with its respective District Court with respect to the funding of such court's administrative expenses for proceedings pursuant to the AOT, it is unclear whether a participating municipality or county is required to fund all of the court's administrative expenses. Additionally, the bill requires the AOC, generally, rather than a District Court, to undertake the following activities which will require the expenditure of funds and personnel: 1) consult with the Behavioral Health Services Division of the Human Services Dept. and the Interagency Behavioral Health Purchasing Collaborative to prepare educational and training materials on the provisions of the AOTA for providers, judges, court personnel, peace officers and the general public by January 1, 2017 (Section 15); and 2) provide quarterly the information reported to it by District Court clerks to the Human Services Department and the Interagency Behavioral Health Purchasing Collaborative beginning September 1, 2016.

In summary, general fund issues have been described by AOC and HSD. Agencies are also concerned about services described in the AOT legislation that are not billable to Medicaid or other sources and the possibility of the unavailability of AOT services in rural communities. Another issue identified by agencies is the quality of service available in communities.

SIGNIFICANT ISSUES

UNM mentioned when responding to similar 2015 legislation that one of largest single issues impacting the implementation of AOT in New Mexico is the lack of provider resources in many areas of the state and the service gaps in needed levels of care. Over time the behavioral health

infrastructure in New Mexico has degraded significantly, which has created significant challenges for behavioral health patients being able to access needed services. In order for AOT to work, patients must be able to access needed treatment services in a timely and efficient manner. Currently there are large infrastructure gaps in need levels of care for patients in Bernalillo County, and more so in other parts of New Mexico. In order for AOT to be successful it is equally as important for services to be developed to meet the needs of patients.

DOH stated that the courts may only be able to initiate AOT for individuals that are already tied into a provider system, who have a payor source, who have interested parties in their life that can access the courts and who have treatment services available in their community; as such the program may not be equally accessible for all New Mexicans and perhaps the least accessible to individuals in rural areas of the state and / or those that are indigent.

DOH comments in response to the similar 2015 legislation included the following:

- Some services allowed in an AOT order outlined under the definition of "assisted outpatient treatment" may not all be billable services, which could lessen or eliminate their availability or the practical application of this legislation. A study of the New York state AOT Program found that, to be successful in reducing inpatient hospitalization and reducing violence, an AOT program was dependent on the availability of high –quality services in the community. (Duke University School of Medicine Study, American Journal of Psychiatry, 2013)
- With an AOT order, there is not a routine review of a person's capacity to make mental health treatment decisions built into the process as there is with civil commitment (See NMSA 43-1-11 F.). This review would be helpful to identify if the person has capacity to make decisions or if they need an alternate decision maker. That would benefit further treatment and give context and information about their "voluntariness" and could ultimately assist in the provision of services given the need for informed consent.

According to HSD in response to similar 2015 legislation, the bill requires an evaluation of the respondent by a "qualified professional," defined on page 5 to include physicians, licensed psychologists, prescribing psychologist, certified nurse practitioners or clinical nurse specialists with a mental health specialty, or physician assistants with a mental health specialty. Inexperience with the court and AOT processes among those groups might lead to confusion in the courts, so requiring additional training for the new responsibilities would be appropriate before participating. Expanding the category to include independently licensed mental health professionals would make services more accessible in some communities. Expanding that category would also make those professionals eligible to file petitions to order AOT, and that could improve the AOT process because those could be the most appropriate persons to file if they happen to be the only professionals who have treated the respondent within the past forty-eight months.

ADMINISTRATIVE IMPLICATIONS

According to HSD, Medicaid would have to change Centennial Care contracts and regulations to account for this new type of service and facilitate timely enrollment, to the extent possible. MCO's would have to adjust care coordination and utilization management processes to accommodate AOT. The bill appears to involve the existing service array.

To the extent that disputes arise between Medicaid-eligible patients and either the MCO's or Medical Assistance Division about coverage for court-ordered services, the HSD Fair Hearings Bureau would be responsible for providing administrative hearings regarding adverse actions, and the HSD Office of General Counsel would provide representation in hearings and appeals. There is no appropriation to HSD for these responsibilities.

TECHNICAL ISSUES

The bill does not address the application of the AOT procedure in tribal communities, nor does it provide an exemption.

EC/jo/jle

LFC Requester:	Eric Chenier

ADMINISTRATIVE OFFICE OF THE COURTS
BILL ANALYSIS
2016 REGULAR SESSION

This bill analysis is submitted by the AOC and shall not be construed as a submission by the Supreme Court or any other court.

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Check all that apply:

Original X **Amendment** ___
Correction ___ **Substitute** ___

Date 1/26/15
Bill No: HB 198

Sponsor: Representative Paul A. Pacheco
Short Title: Assisted Outpatient Treatment Act

Agency Code: 218
Person Writing Kathleen Sabo
Phone: 505-827-4813 **Email** aoccaj@nmcourts.gov

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY16	FY17		
None	None	Rec.	General

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY16	FY17	FY18		
Unknown	Unknown	Unknown	Rec.	General

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	Unknown	Unknown	Unknown	Unknown	Rec.	General

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: SB 113 is a duplicate bill.

Duplicates/Relates to Appropriation in the General Appropriation Act: None.

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: HB 198 enacts the Assisted Outpatient Treatment Act (AOTA), providing court-ordered outpatient services "prescribed to treat a patient's mental disorder and to assist a patient in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in harm to the patient or another or the need for hospitalization," as such treatment is defined in the bill. The bill permits a petition for an order authorizing assisted outpatient treatment (AOT) to be filed in the District Court for the county in which the respondent is present or reasonably believed to be present, provided that the District Court is a party to a memorandum of understanding (MOU) with a participating municipality of county. **(Section 4(A))** (HB 198 defines "participating municipality of county" to mean a municipality or county that has entered into an MOU with its respective District Court with respect to the funding of such District Court's administrative expenses for proceedings pursuant to the AOTA. **(Section 2(K)**))

Under the proposed legislation, assisted outpatient treatment (AOT) may include the following:

- 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 and substance abuse treatment and counseling;
- periodic blood tests or urinalysis for presence of alcohol or drugs for patient with substance abuse history;
- supervision of living arrangements; and
- any other services prescribed to treat the patient's mental disorder and to assist a patient in living and functioning in the community or to attempt to prevent a relapse or deterioration of the patient's mental or physical condition.

The AOTA provides a procedure by which specified persons (**Section 4**) can file a petition for a court order authorizing AOT. The petition is required to contain criteria for AOT as set forth in Section 3 of the bill, facts supporting petitioner's belief respondent meets each criterion, and whether respondent is present or reasonably believed to be within the county where the petition is filed. Under the bill, a court is permitted to order a person to participate in AOT if the court finds by clear and convincing evidence that the person:

a. is 18 or older and a resident of a participating municipality or county;
b. has a primary diagnosis of a mental disorder;
c. has demonstrated a history of lack of compliance with treatment for a mental disorder (as described in **Section 3(C)(1) through (3)**);
d. is unwilling or unlikely, as result of mental disorder, to participate voluntarily in outpatient treatment that would enable the person to live safely in the community without court supervision;

e. is in need of AOT as the least restrictive appropriate alternative to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others; and
f. will likely benefit from, and the person's best interests will be served by receiving AOT.

HB 198 requires the petition to be accompanied by an affidavit of a qualified professional stating that: a. the qualified professional has personally examined the respondent, no more than 10 days prior to filing of petition, recommends AOT for respondent, and is willing and able to testify at the hearing on the petition either in person or by contemporaneous transmission from a different location; or b. the qualified professional or designee, no more than 10 days prior to filing of petition, has unsuccessfully attempted to persuade respondent to submit to examination, has reason to believe respondent meets AOT criteria, and is willing and able to testify at the hearing on the petition either in person or by contemporaneous transmission from a different location. Additionally, the petition is required to be accompanied by a motion seeking Qualified Protective Order **[Section 5],** governing the disclosure of protected health information, as defined in the bill's amendment to Section 43-1-3(R) NMSA 1978.

Section 6 of the bill governs the required hearing on the petition for AOT. Under the bill, the court, upon receipt of a petition, is required to set a date for a hearing: 1) no sooner than 3 or later than 7 days after date of service or as stipulated by the parties, or, upon a showing of good cause, no later than 30 days after service; or 2) before discharge of respondent and in sufficient time to arrange for continuous transition from inpatient treatment to AOT, if the respondent is hospitalized at the time of filing of the petition. The bill requires that the respondent be represented by counsel throughout the proceedings, and provides that the required hearing may be held in respondent's absence if respondent's counsel is present.

HB 198 permits the court to order a mental examination of the respondent, pursuant to Rule 1-035(A) NMRA, when the respondent has refused to be examined by the qualified professional whose affidavit accompanied the petition. The examination may be performed by the qualified professional whose affidavit accompanied the petition, or by another qualified profession authorized to consult with the qualified professional whose affidavit accompanied the petition. In the event the respondent has refused to be examined by a qualified professional and the court finds reasonable grounds to believe that the allegations of the petition are true, the court may issue a written order directing a peace officer with completed crisis intervention training (CIT) to detain – for no longer than necessary to complete the examination and in no event longer than 24 hours – and transport respondent to a provider for examination by a qualified professional.

Under the bill, the court is prohibited from ordering AOT unless a qualified professional, who has personally examined the respondent within 10 days of filing of the petition, testifies at a hearing in support of the finding that the respondent meets AOT criteria, and provides testimony on the written proposed treatment plan, without which the court is prohibited from ordering AOT **[Section 7**], including:

a. recommended AOT, rationale for recommended AOT and facts that establish that such treatment is least restrictive appropriate alternative;
b. information regarding respondent's access to, and availability of, recommended AOT in the community or elsewhere; and
c. types or classes of medication that should be authorized, if AOT treatment included medication, beneficial and detrimental physical and mental effects of such medication, and whether such medication should be self-administered or administered by a specified provider.

(The court is prohibited from ordering AOT for a respondent with a surrogate decision-maker

without notice to such person and an opportunity for a hearing as provided in Section 6.)

Under the proposed legislation, the treatment plan is required to state all treatment services recommended for the respondent and, for each such service, to specify a provider that has agreed to provide the service. The qualified professional, in developing a written proposed treatment plan, is required to take into account an existing advance directive for mental health treatment, and to provide an opportunity to participate to: the respondent; all current treating providers; upon the request of the respondent, an individual significant to the respondent, including any relative, close friend or individual otherwise concerned with the welfare of the respondent; and any surrogate decision-maker. The plan is required to include case management services or an assertive community treatment team to provide care coordination and AOT services recommended by the qualified professional. If the plan includes medication, it shall state whether the medication should be self-administered or administered by a specific provider, and shall specify type and dosage range of medication. The plan is prohibited from recommending the use of physical force or restraints to administer medication to the respondent. If the plan includes alcohol or substance abuse counseling and treatment, the plan is permitted to include a provision requiring relevant testing, providing the qualified professional's clinical basis for recommending such plan provides sufficient facts for the court to find that the respondent has a history of co-occurring alcohol or substance abuse, and such testing is necessary to prevent a relapse or deterioration that would be likely to result in serious harm to others. **(Section 7)**

The bill provides that after a hearing and consideration of all relevant evidence, the court is required to order respondent to receive AOT if the court finds by clear and convincing evidence that respondent meets all AOT criteria. **(Section 3)** The court's order is required to:

1) a. provide for period of outpatient treatment, not to exceed one year;
b. specify the AOT services that the respondent is to receive (court may not order treatment not recommended by qualified professional and included in treatment plan, nor direct participation of provider not specified in plan); and
c. direct one or more specified providers to provide or arrange for all AOT for patient throughout the period of the order.

2) State the type or types of medication and necessary dosage range, based on treatment plan and evidence presented, if court order includes medication. Court may order respondent to self-administer medication or accept administration of medication by specified provider. Court prohibited from requiring or authorizing the use of physical force or restraints to administer medication to the respondent.

3) Follow the decisions of respondent's surrogate decision maker or an advance directive for mental health treatment, in determining the treatment order, unless good cause shown to order otherwise. (Court prohibited from ordering AOT for respondent with surrogate decision-maker without notice to such person and an opportunity for a hearing as provided in **Section 6**.)

HB 198 provides that the court may order AOT: a. in lieu of involuntary inpatient commitment if it finds AOT to be the least restrictive appropriate alternative; or b. as a means of jail diversion.

Section 9 of the bill provides for a right to an expeditious appeal from a final order in a proceeding under the AOTA.

The bill provides that an AOT order shall not be construed as a determination that the respondent is incompetent. **(Section 10)**

Section 11 of HB 198 permits a party or the respondent's surrogate decision-maker to apply, prior to the expiration of the period of AOT, for a continued period of treatment for one year or less. The disposition of the application is required to occur no later than 10 calendar days following filing of the application. The proposed legislation provides that if the disposition does

not occur prior to the expiration of the date of the current order, the current order shall remain in effect until the court's disposition. Under the bill, the court is permitted to order respondent to participate in continued AOT is court finds by clear and convincing evidence that respondent:

a. continues to have primary diagnosis of mental disorder;

b. is unwilling or unlikely, as a result of mental disorder, to participate voluntarily in outpatient treatment that would enable respondent to live safely in community without court supervision;

c. is in need of continued AOT as the least restrictive appropriate alternative in order to prevent a relapse or deterioration likely to result in serious harm to self or likely to result in serious harm to others; and

d. will likely benefit from, and the respondent's best interests will be served by, receiving continued AOT.

Section 12 of the bill permits a party or respondent's surrogate decision-maker to apply to the court to stay, vacate, modify or enforce an order. HB 198 requires a provider applying to the court for approval before instituting a proposed material change, as defined in the bill, in mandated services of AOT unless such change is contemplated in the original order. The disposition of the application is required to occur no later than 10 calendar days following filing of the application. The bill further provides that a court order requiring periodic blood tests or urinalysis for the presence of alcohol or abused substances shall be subject to review after six months by a qualified professional, who shall be authorized to terminate such blood tests or urinalysis without further action by the court.

Section 13 of the bill requires a qualified professional who determines that a respondent has materially failed to comply with the AOT as ordered by the court, such that the qualified professional believes that the respondent's condition is likely to result in serious harm to self or likely to result in serious harm to others and that immediate detention is necessary to prevent such harm, to certify the need for detention and transport of respondent for emergency mental health evaluation and care pursuant to Section 43-1-10(A)(4) NMSA 1978.

HB 198 requires that all records or information containing protected health information relating to the respondent be confidential and closed to the public. The bill specifies those persons to whom the information may be disclosed. The bill provides a fourth degree felony penalty for a person who intentionally releases any information or records closed to the public pursuant to the AOTA or who releases or makes other use of the records in violation of that Act. **(Section 14)**

Section 15 of the bill requires the Behavioral Health Services Division of the Human Services Dept. and the Interagency Behavioral Health Purchasing Collaborative, in consultation with the Administrative Office of the Courts (AOC), to prepare educational and training materials on the provisions of the AOTA for providers, judges, court personnel, peace officers and the general public by January 1, 2017.

HB 198 provides definitions within **Section 2** for the following terms, as used in the AOTA: "advance directive for mental health treatment"; "agent"; "assertive community treatment"; "assisted outpatient treatment"; "covered entity"; "guardian"; "least restrictive appropriate alternative"; "likely to result in serious harm to others"; "likely to result in serious harm to self"; "mandated service"; "participating municipality or county"; "patient"; "power of attorney for health care"; "provider"; "qualified professional"; "qualified protective order"; "respondent"; "surrogate decision-maker"; and "treatment guardian". The bill also amends Section 43-1-3 NMSA 1978 to add a definition of "protected health information," as used in the Mental Health and Developmental Disabilities Code. **(Section 16)**

The bill amends Section 43-1-19 NMSA 1978, also within the Mental Health and Developmental Disabilities Code, to provide that authorization from the client shall not be required for the disclosure or transmission of confidential information when the disclosure is

made pursuant to the provisions of the AOTA, using reasonable efforts to limit protected health information to that which is minimally necessary to accomplish the intended purpose of the use, disclosure or request. **(Section 17)**

Section 18 of the bill requires the clerk of each court with jurisdiction to order AOT pursuant to the AOTA or involuntary commitment pursuant to the Mental Health and Developmental Disabilities Code to provide a monthly report to the AOC with specified information for the previous month. The bill also requires the AOC, beginning September 1, 2016, to quarterly provide the information reported to it to the Human Services Department and the Interagency Behavioral Health Purchasing Collaborative. The bill clarifies that the production of protected health information, information deemed confidential under Section 14(A) of the AOTA or information protected from disclosure under Section 43-1-19 NMSA 1978 is not required.

FISCAL IMPLICATIONS

The AOC is in the process of determining potential fiscal implications associated with the proposed legislation, including the cost of contracting for attorney services potentially required by the AOTA, as well as personnel costs, training and education costs, data compilation and reporting costs, and other associated costs. Although the bill permits AOT only where a municipality or county has entered into an MOU with its respective District Court with respect to the funding of such court's administrative expenses for proceedings pursuant to the AOTA, it is unclear whether a participating municipality or county is required to fund all of the court's administrative expenses. Additionally, the bill requires the AOC, generally, rather than a District Court, to undertake the following activities which will require the expenditure of funds and personnel: 1) consult with the Behavioral Health Services Division of the Human Services Dept. and the Interagency Behavioral Health Purchasing Collaborative to prepare educational and training materials on the provisions of the AOTA for providers, judges, court personnel, peace officers and the general public by January 1, 2017 (Section 15); and 2) quarterly provide the information reported to it by District Court clerks to the Human Services Department and the Interagency Behavioral Health Purchasing Collaborative beginning September 1, 2016.

There will be a minimal administrative cost for statewide update, distribution and documentation of statutory changes. Any additional fiscal impact on the judiciary would be proportional to the enforcement of this law and commenced prosecutions, and appeals from convictions. New laws, amendments to existing laws and new hearings have the potential to increase caseloads in the courts, thus requiring additional resources to handle the increase.

SIGNIFICANT ISSUES

1) Unlike 2015's Senate Judiciary Committee Substitute for SB 53, enacting the AOTA, HB 198, Section 3(A) requires the court to find by clear and convincing evidence that a respondent is a resident of a "participating municipality or county", defined in Section 2(K) to mean a municipality or county that has entered into an MOU with its respective District Court with respect to the funding of such District Court's administrative expenses for proceedings pursuant to the AOTA. While the funding of a court's administrative expenses will go some way toward permitting AOTA procedures to move forward, it does not guarantee that the municipality or county will have the necessary services for each respondent. Section 7(A) prohibits a court from ordering AOT unless a qualified professional provides a written proposed treatment plan to the court, required to state all treatment services recommended for the respondent and to specify a provider that has agreed to provide each service. Section 6(H)(2) requires a qualified professional to testify regarding the respondent's access to, and the availability of, recommended AOT "in the community or elsewhere".

2) Significant impacts upon the courts related to the enactment of the AOTA are anticipated as follows:

- The court may be required to provide counsel to the respondent throughout AOT proceedings. (This is supposed, but unclear. SB 53, introduced in 2015, enacting the AOTA, initially contained an appropriation from the General Fund to the AOC to "contract for attorney services required by the AOTA". This appropriation was amended out of the Senate Judiciary Committee's Substitute Bill by the Senate Finance Committee (SFC).) The only reference to representation by counsel in HB 198 provides that, "The respondent shall be represented by counsel at all stages of the proceeding." **Section 6(D))**
- Throughout the contemplated AOT proceedings, the court is dependent upon others to provide detailed testimony and documentation, and to invite and gather together and secure the participation of multiple parties and persons and providers. HB 198 is silent as to whether it is up to the court to police required actions and procedures, such as whether an appropriate person has filed a petition **(Section 4(A))**, whether a written proposed treatment plan is sufficient **(Section 7(A)(C) and (D))**, or whether the required persons have been invited to participate in the development of the proposed plan. **(Section 7(B))** There is no direction in the bill as to whether the court, upon a determination that legislative requirements for AOT have not been met, is permitted to reject the petition and/or dismiss the petition, or whether the challenge to the petition and legislative requirements is to come from a person other than the court, and who that person could be.
- There is no direction in the bill that petition proceedings occur in existing Mental Health Courts. Given the education necessary to permit court personnel, including judges, to approach petition proceedings with the necessary deep understanding of issues surrounding mental illness, and the lack of anticipated education resources and an appropriation to support extensive education, other than the preparation of educational and training materials required to be prepared pursuant to **Section 15**, the court will be required to expend existing administrative and financial resources, including time away from administering justice in courtrooms, to educate all court personnel on the specialized issues arising in the mental health arena.
- HB 198 requires the court to provide for expeditious appeal from a final order in a proceeding under the AOTA. **(Section 9)** While there is no direction as to what is an "expeditious appeal," nor a timetable for hearing an appeal, the need for an expeditious appeal may cause essential court resources to be diverted from other matters.
- With regard to both Applications for Continued Periods of AOT **(Section 11)** and Applications to Stay, Vacate, Modify or Enforce an Order **(Section 12),** the court is required to rule on the application no later than 10 calendar days following the filing of the application. Even if the court entertaining the application is the same court that ruled on the original petition, there will be much new evidence submitted and to be considered, and a potential hearing to be held, thus redirecting potentially significant judicial resources away from the court's already-scheduled hearings and proceedings.

3) HB 198 is silent as to whether a petitioner for court-ordered AOT is permitted to participate in the hearing and appeal and other procedures required and/or permitted under the AOTA, and whether the petitioner is entitled to counsel during the resulting proceedings.

4) HB 198 is silent as to when a petition for court-ordered AOT may be filed. May the petition or must the petition be filed during an existing proceeding? If the existing proceeding is a

criminal case, is the AOT matter heard within the existing proceeding, by the same judge and jury? If the petition is filed outside of an existing or pending criminal proceeding, does the court entertaining the petition have jurisdiction to order AOT as a means of jail diversion, as permitted in **Section 8(G)(2),** or must the petition only arise during a criminal proceeding, if such criminal proceeding is ongoing or pending? With whom must the court consult before ordering AOT as a means of jail diversion?

5) **Section 3** provides that a person *MAY* be ordered to participate in AOT if the court finds by clear and convincing evidence that the person meets specified criteria. **Section 8(A)** provides, however, that, after a hearing and consideration of all relevant evidence, the court *SHALL* order the respondent to receive AOT if it finds by clear and convincing evidence that the respondent meets all Section 3 criteria. (Emphasis added.) It is unclear whether, upon finding by clear and convincing evidence that a person meets Section 3 criteria for AOT, the court is required or permitted to order AOT.

6) **Section 5** of the bill calls for a Motion for Qualified Protective Order to accompany the petition. Presumably, this is a motion pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, otherwise known as "HIPPA." The AOTA does not, however, reference HIPPA or any relevant portions of HIPPA. The bill requires a court to determine which parties to the proceeding are authorized to receive, subpoena and transmit protected health information regarding the proceedings, yet the bill does not provide the factors the court is to consider in deciding which parties may receive, subpoena and transmit respondent's protected health information.

7) **Section 6** of the bill requires the court to set a date for a hearing: 1) no sooner than 3 or later than 7 days after date of service or as stipulated by the parties, or, upon a showing of good cause, no later than 30 days after service; or 2) before discharge of respondent and in sufficient time to arrange for continuous transition from inpatient treatment to AOT, if the respondent is hospitalized at the time of filing of the petition. The bill requires that the respondent be represented by counsel throughout the proceedings, and provides that the required hearing may be held in respondent's absence if respondent's counsel is present. There is no direction as to whether the court may inquire about the interactions of respondent and counsel, and what actions the court may take if counsel has not met with respondent. There is a concern that the limited timeframe contemplated between the filing of the petition and the scheduling of the hearing may impact the ability of counsel to adequately represent the respondent.

8) **Section 9** of the bill requires the court to provide for an expeditious appeal from a final order in a proceeding under the AOTA. There is no direction as to what constitutes an "expeditious appeal," nor a timetable for hearing an appeal. Additionally, there is no direction as to who may file an appeal (whether a petitioner, respondent surrogate decision-maker, provider, qualified professional, individual significant to the respondent who has participated in the development of a proposed written treatment plan), nor is there direction as to what evidence is to be considered on appeal, who must be present at any appeal proceeding, or whether the court hearing the appeal must be a specialized or designated court for such AOT appeals.

9) **Section 11** of the bill permits a court to order a respondent to participate in continued AOT if the court finds by clear and convincing evidence that the respondent meets specified criteria and requires the court to rule on the application for continued treatment no later than 10 days following the filing of the application. There is no direction as to whether the applicant is required to provide an additional/augmented/extended treatment plan, nor whether the court is required to hold a

hearing, permitting the respondent or respondent's counsel, or other party or person to challenge or clarify the need for continued AOT. Nor is there, pursuant to **Section 12**, direction as to whether the person filing, or a person wishing to contest, an application to stay, vacate, modify or enforce an order for AOT is entitled to a hearing.

10) **Section 13** of the bill provides that a qualified professional is required to certify the need for detention and transport of the respondent for emergency mental health evaluation and care pursuant to Section 43-1-10(A)(4) NMSA 1978, if the professional determines the respondent has materially failed to comply with the AOT as ordered by the court, such that the qualified professional believes that the respondent's condition is likely to result in serious harm to self or likely to result in serious harm to others and that immediate detention is necessary to prevent such harm. The bill does not address whether respondent, respondent's counsel or respondent's surrogate decision-maker is permitted to contest the emergency mental health evaluation and care and whether the court is required to entertain, expeditiously, respondent's/respondent's counsel's/respondent's surrogate decision-maker's challenge to the evaluation and care.

11) While **Section 17** of the bill amends the existing Section 43-1-19 NMSA 1978 to provide that authorization from the client is not required for disclosure or transmission of confidential information when the disclosure is made pursuant to the AOTA, using reasonable efforts to limit protected health information to that which is minimally necessary to accomplish the intended purpose of the use, disclosure or request, there is no guidance provided as to what constitutes "reasonable efforts."

12) The bill does not contain a penalty for "false petition," for making a false statement or providing false information or false testimony in a petition or hearing for AOT.

13) It is unclear how providing court-ordered AOT for individuals who already have a guardian or mental health treatment guardian will affect those existing roles. The AOC has prepared a chart comparing mental health treatment guardian procedures (Section 43-1-15 NMSA 1978) with HB 198 AOT procedures (attached).

PERFORMANCE IMPLICATIONS

The courts are participating in performance-based budgeting. This bill may have an impact on the measures of the district courts in the following areas:

- Cases disposed of as a percent of cases filed
- Percent change in case filings by case type

ADMINISTRATIVE IMPLICATIONS

1) There is no direction in the bill that petition proceedings occur in existing Mental Health Courts. Given the education necessary to permit court personnel, including judges, to approach petition proceedings with the necessary deep understanding of issues surrounding mental illness, and the lack of anticipated education resources and an appropriation to support extensive education, other than the preparation of educational and training materials required to be prepared pursuant to **Section 15**, the court will be required to expend existing administrative and financial resources, including time away from administering justice in courtrooms, to educate all court personnel on the specialized issues arising in the mental health arena.

2) HB 198 requires the court to provide for expeditious appeal from a final order in a proceeding under the AOTA. **(Section 9)** While there is no direction as to what is an "expeditious appeal,"

nor a timetable for hearing an appeal, the need for an expeditious appeal may cause essential court resources, including court personnel, to be diverted from other matters.

3) With regard to both Applications for Continued Periods of AOT **(Section 11)** and Applications to Stay, Vacate, Modify or Enforce an Order **(Section 12),** the court is required to rule on the application no later than 10 calendar days following the filing of the application. Even if the court entertaining the application is the same court that ruled on the original petition, there will be much new evidence submitted and to be considered, and a potential hearing to be held, thus redirecting potentially significant judicial resources, including court personnel, away from the court's already-scheduled hearings and proceedings.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
SB 113 is a duplicate bill.

TECHNICAL ISSUES
1) Section 7 of the bill requires the qualified professional, in developing the written proposed treatment plan, to provide, upon the request of the respondent, an individual significant to the respondent with an opportunity to participate. It is unclear whether the participation requirement is limited to only one individual significant to the respondent or if the respondent may request the participation of multiple individuals.

OTHER SUBSTANTIVE ISSUES

I. Constitutional Questions

It can be anticipated that there will be challenges to the constitutionality of the proposed AOTA. The United States Supreme Court has not heard a case concerning AOT. Some lower courts have, particularly concerning New York's Kendra's Law. Below is a brief consideration of constitutional issues and challenges that may be made should the Bill become law.

A. Substantive Due Process

The Due Process Clause of the Fourteenth Amendment to the United States Constitution, Section 1, provides that "[n]o State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law…"

The courts have developed a three-prong analysis when considering substantive due process claims. The courts evaluate: (1) the compelling nature of the government's objective; (2) the liberty interests sacrificed in furthering the government's objective; and (3) whether the means and ends implicate the least restrictive alternative doctrine in the context of mental health law." *See, e.g., Roe v. Wade*, 410 **U.S.** 113, 155 (1973) (holding that a regulation limiting "fundamental rights" must be narrowly tailored to a "compelling state interest"); *Griswold v. Connecticut*, 381 **U.S.** 479, 485 (1965) (noting that such regulation may not sweep too broadly).

HB 198, Section 6(H)(1) requires the qualified professional to testify that the recommended AOT is the least restrictive appropriate alternative. The courts, however, will also look to the respondent's deprivation of liberty when he or she is forced to undergo treatment. These liberty interests will be balanced against the objectives of the government, whether they be a police power based goal of protecting society from violent acts committed against the innocent by the mentally ill, or the paternalistic, *parens-patrie*-based goal of treating citizens for their own good. The bill contains procedures that infringe upon the respondent's liberty, in providing for a

court-ordered examination when the qualified professional testifies during the hearing that the respondent has refused to be examined, and allowing the respondent to be held for twenty-four hours or less (Section 6(G)), and in providing for the detention and transport of the respondent for emergency mental health evaluation and care pursuant to Section 43-1-10(A)(4) NMSA 1978, when the respondent has materially failed to comply with court-ordered AOT such that the qualified professional believes that the respondent's condition is likely to result in serious harm to self or others and that immediate detention is necessary to prevent such harm. (Section 13(A))

The court will look to see if the law is narrowly tailored and rationally related to its goals of caring for the mentally ill (*parens patrie*) and protecting innocent members of society from the violent actions of the mentally ill (police power), and whether these goals are compelling enough to justify the law's restrictions on the respondent's liberty.

B. Procedural Due Process

The purpose of procedural due process analysis is "to determine whether a state has provided adequate procedures to minimize efficiently the risk of arbitrary or erroneous deprivations of life, liberty, or property." *Thibodeaux v. Bordelon*, 740 F.2d 329, 336 (5th Cir. 1984) In *Matthews v. Eldridge,* 424 U.S. 319, 332 (1976), the Supreme Court outlined the factors that must be considered, as required by procedural due process, when a liberty interest is at stake. First, [the court must consider] the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used [; third, the] value **...** of additional or substitute... safeguards; and finally, the Government's interest, including the **...** fiscal and administrative burdens that the additional or substitute procedural [safeguards] would entail. *Id.* at 335. This balancing test requires that the procedural protections afforded correspond to the level of infringement on liberty that the state action poses. Ilissa L. Watnik, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 UPENN Law Rev. 1181, 1208 (2001)

In evaluating a claim of violation of procedural due process, the court will look to see whether HB 198 provides for adequate representation by counsel, whether the respondent is afforded necessary hearings and opportunities to testify and present witnesses and evidence and cross-examine adverse witnesses, whether adequate notice of hearings is provided for, whether the detention of the respondent for any period of time prior to the hearing on the petition will interfere with respondent and counsel's preparation, whether there is the provision of expert fees to rebut the findings of an involuntary examination, whether allowing the qualified professional to testify contemporaneously from another location affords the respondent a sufficient opportunity to confront the qualified professional.

C. Equal Protection

The Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, Section 1, states that "[n]o State shall…deny to any person within its jurisdiction the equal protection of the laws."

The court, in evaluating a claim of equal protection violation, will decide which standard of review to apply: rational basis (attaching a presumption of validity to the reasonableness of the classification, placing the burden on the party challenging its legitimacy); intermediate scrutiny (requiring the state to prove that the classification is substantially related to important governmental interests; or strict scrutiny review (requiring the state to demonstrate that the classification is the least restrictive means of furthering a compelling state interest.)

Strict scrutiny review is used only when a classification threatens a fundamental right

> or disadvantages a "suspect" class. If the least restrictive means are not used and the statute is determined to be over-inclusive, then the statute is considered to be motivated by bias and is declared unconstitutional. If the mentally ill were characterized as a suspect class, then the states' commitment schemes would be subject to a more critical review. The states would be compelled to develop and fund community-based alternatives. If the mentally ill are not afforded suspect class protection, however, then the states' commitment schemes would be considered constitutional if there were a mere rational relation between means and ends, and the states would be under no obligation to provide less restrictive alternatives of treatment. *See* Watnik*, supra, at 1211.*

The court will first need to determine whether the law disadvantages a suspect class, triggering strict scrutiny review of the law, or not. If the court analyzes the law under a rational relation basis standard of review, the court would only need to find that the ends and the means used to achieve them are at least rationally related.

D. Separation of Powers

It can be anticipated that an argument may be made that in not providing a mechanism for a court to enforce an order issued for a respondent to participate in AOT, other than necessary detention and transport of the respondent upon the certification of a qualified professional, for emergency mental health evaluation and care pursuant to Section 43-1-10(A)(4) NMSA 1978 (Section 12 and 13), HB 198 violates the separation of powers clause, Article 3, Section 1 of the New Mexico Constitution, and is an impermissible intrusion upon the judiciary's powers, as not expressly directed or permitted within the constitution.

II. Comparison With NY's "Kendra's Law"

A. Comparison of Services

An important difference between the New York law and the proposed New Mexico law lies not in the text of the laws themselves, but rather in the existence of services supporting the law in New York, versus the absence of necessary services to support enactment of the law in New Mexico.

A documented example of available services in New York City (NYC) can be found in the November 19, 2010 testimony of Dr. Adam Karpati, Executive Deputy Commissioner for the Division of Mental Hygiene, New York City Department of Health and Mental Hygiene, before the New York Council Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse, and Disability Services, regarding oversight of New York's Kendra's Law. Dr. Karpati writes

> [Kendra's Law] stipulates that the local government unit - here in New York City, the Department of Health and Mental Hygiene [DOHMH] - is responsible for monitoring and oversight of the implementation of Kendra's Law. At program inception, DOHMH designated the Health and Hospitals Corporation as the operator of AOT and established programs for each of the five boroughs, as well as one focusing exclusively on Riker's Island. Each AOT team is housed in an HHC facility. There are two AOT teams at Bellevue Hospital that serve Manhattan and Riker's Island; a team at Woodhull Hospital that serves Brooklyn and Staten Island; a team at Elmhurst Hospital that serves the borough of Queens; and a team at North Central Bronx Hospital that serves the Bronx. The teams include psychiatrists, lawyers, social workers, peer counselors and data coordinators. The

psychiatrists examine individuals for eligibility and testify in court with the lawyers. Social workers and peer counselors monitor the implementation of court orders that have been granted and address issues of compliance if and when they arise. Data coordinators ensure that we have sufficient information to monitor program performance and evaluate the efficacy of our interventions.

Not only has the NYC program had ready and consolidated services since the inception of the program, NYC, at the time of and according to Dr. Karpati's testimony, was working to improve services, as follows:

> DOHMH is currently in the process of assuming direct responsibility for operating AOT. This transfer of function from HHC to DOHMH will result in a single AOT program for all of New York City. The unified program will investigate, petition and monitor AOT court orders in much the same way they have since the program's inception. The main advantage of the new organization will be DOHMH's enhanced capacity to ensure that consumers and providers across New York City interface with a single AOT program that is capable of applying resources more flexibly and efficiently across the boroughs.
>
> http://www.nyc.gov/html/doh/downloads/pdf/public/testi/testi20131119.pdf

Given the example of how NYC was providing and preparing to provide AOT services in 2010, the question arises whether New Mexico – any municipality or geographical region – can adequately access or create necessary services that will support the proposed AOTA and its procedures and requirements in the near future.

B. Comparison of Provisions of the Laws

There are myriad small differences between New York's law and the proposed New Mexico law. Those differences that may impact clients and potential constitutional challenges to the proposed law the most are:

- New York's Section 9.60(e)(4) provides for the right to be represented by the Mental Hygiene Legal Service, or privately financed counsel, at all stages of the proceeding. HB 198, Section 6(D) provides that a respondent shall be represented by counsel at all stages of the proceeding.
- New York's Section 9.60(h)(1) requires the hearing to happen no sooner than 3 days from the date petition received by court, excluding Saturdays, Sundays and holidays. The law further provides that adjournments shall be permitted only for good cause shown. The bill, Section 6(A)(1) requires a hearing to happen no sooner than 3 days or later than seven days after the date of service or as stipulated by the parties, or upon a showing of good cause, no later than thirty days after the date of service; or (2) if the respondent is hospitalized at the time of filing of the petition, before discharge of the respondent and in sufficient time to arrange for a continuous transition from inpatient treatment to assisted outpatient treatment.
- The bill's Section 6(E) permits the court to conduct a hearing in the absence of respondent if counsel present. New York's Section 9.60(h)(1) permits the court to conduct a hearing if appropriate attempts to secure attendance have failed, and requires the court to set forth the factual basis for conducting the hearing without the presence of the subject of the petition.

- New York's Section 9.60(h)(2) requires the examining physician to testify in person at the hearing. HB 198, Section 6(H) requires the qualified professional to testify at the hearing in person or by contemporaneous transmission from a different location.
- New York's Section 9.50(h)(3) requires a subject who has refused examination to be taken by law enforcement to a hospital for examination by a physician. The bill's Sections 6(F) and (G) require transport to a "provider" for examination. (Section 2(M) defines "provider" to mean an individual or organization licensed, certified or otherwise authorized or permitted by law to provide mental or physical health diagnosis or treatment in the ordinary course of business or practice of a profession.)
- In addition to testimony from a qualified professional that New York's law also requires in Section 9.60(h)(4), the bill, Section 6(H), requires testimony about the respondent's access to, and the availability of, recommended AOT "in the community or elsewhere".
- New York's Section 9.60(h)(5) requires the subject of the petition to be offered an opportunity to present evidence, to call witnesses on his or her behalf, and to cross-examine adverse witnesses. HB 198 does not contain such provision.
- New York's Section 9.60(i)(1) requires all service providers to be notified regarding their inclusion in the written treatment plan. The bill, Section 7(A), requires the treatment plan to specify, for each service, a provider that has agreed to provide the service.
- New York's Section 9.60(i)(1) requires the treatment plan to state whether medication should be self-administered or administered by authorized personnel, and to specify the type and dosage range of medication most likely to provide maximum benefit for the subject. HB 198, Section 7(A) requires specificity re: type and dosage range of medication, but does not refer to "medication most likely to provide maximum benefit for the subject."
- New York's Section 9.60(i)(1) permits inclusion of alcohol or substance abuse counseling and/or treatment, provided the physician's clinical basis for recommending such plan provides enough facts for the court to find that the person has a history of alcohol or substance abuse that is clinically related to the mental illness. The bill, Section 7(D) requires the provision of facts sufficient for the court to find that the respondent has a history of co-occurring alcohol or substance abuse.
- New York's Section 9.609(j)(2) permits the court to order an initial period of AOT not to exceed 6 months, while HB 198, Section 8(B) permits an order of AOT up to one year.
- New York's Section 9.60(j)(5) provides that

  > (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.

  HB 198 does not contain such a provision.
- The bill's Section 8(G)(2) permits the court to order AOT as a means of jail diversion. New York's law does not contain such a provision.
- New York's law, Section 9.60(k)(1), requires petition for additional period of treatment to be filed within 30 days prior to the expiration of an order for AOT. HB 198, Section 11(A), requires application to be filed prior to the expiration of the period of AOT.
- HB 198, Section 9, provides a right to an expeditious appeal from a final order in a

proceeding under the AOTA. New York's Section 9.60(m) provides that review of an order issued pursuant to Section 9.60 shall be had in the manner specified in Section 9.35, governing review of court authorization to retain an involuntary patient, which reads

> If a person who has been denied release or whose retention, continued retention, or transfer and continued retention has been authorized pursuant to this article, or any relative or friend in his behalf, be dissatisfied with any such order he may, within thirty days after the making of any such order, obtain a rehearing and a review of the proceedings already had and of such order upon a petition to a justice of the supreme court other than the judge or justice presiding over the court making such order. Such justice shall cause a jury to be summoned and shall try the question of the mental illness and the need for retention of the patient so authorized to be retained. Any such patient or the person applying on his behalf for such review may waive the trial of the fact by a jury and consent in writing to trial of such fact by the court. No such petition for rehearing and review shall be made by anyone other than the person so authorized to be retained or the father, mother, husband, wife, or child of such person, unless the petitioner shall have first obtained the leave of the court upon good cause shown. If the verdict of the jury, or the decision of the court when jury trial has been waived, be that such person is not mentally ill or is not in need of retention the justice shall forthwith discharge him, but if the verdict of the jury, or the decision of the court where a jury trial has been waived, be that such person is mentally ill and in need of retention the justice shall certify that fact and make an order authorizing continued retention under the original order. Such order shall be presented, at the time of authorization of continued retention of such mentally ill person, to, and filed with, the director of the hospital in which the mentally ill person is authorized to be retained, and a copy thereof shall be forwarded to the department by such director and filed in the office thereof. Proceedings under the order shall not be stayed pending an appeal therefrom, except upon an order of a justice of the supreme court, made upon a notice and after a hearing, with provisions made therein for such temporary care or confinement of the alleged mentally ill person as may be deemed necessary.

- New York's Section 9.60(l)(1) and (2) require a hearing to be held no later than 5 days (not including Sat. and Sun.) after the court receives a petition for an order to stay, vacate or modify, or to make a material change in the treatment plan, provided that if the assisted outpatient informs the court that he or she agrees to the proposed material change, the court may approve such change without a hearing. Non-material changes may be instituted by the director without court approval. HB 198, Section 12(B), provides that the disposition of the application (for either stay, vacate or modify or material change by provider) shall occur no later than 10 calendar days following the filing of the application, but does not require a hearing to be held.
- New York's Section 9.60(n) requires that efforts have been made to solicit compliance with AOT, while HB 198, Section 13(A) requires a qualified professional to determine that the respondent has materially failed to comply w/ the AOT ordered by the court, such that the qualified professional

> believes that the respondent's condition is likely to result in serious harm to self or likely to result in serious harm to others and that immediate detention is necessary to prevent such harm, the qualified professional shall certify the need for detention and transport of the respondent for emergency mental health evaluation and care pursuant

to the provisions of Paragraph (4) of Subsection A of Section 43-1-10 NMSA 1978.

NY's law provides that:

> Where in the clinical judgment of a physician, (i) the assisted outpatient, has failed or refused to comply with the assisted outpatient treatment, (ii) efforts were made to solicit compliance, and (iii) such assisted outpatient may be in need of involuntary admission to a hospital pursuant to section 9.27 of this article or immediate observation, care and treatment pursuant to section 9.39 or 9.40 of this article, such physician may request the director of community services, the director's designee, or any physician designated by the director of community services pursuant to section 9.37 of this article, to direct the removal of such assisted outpatient 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 any physician designated pursuant to section 9.37 of this article, may direct 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 assisted outpatient into custody and transport him or her 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 any physician 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. Any director of community services, or designee, shall be authorized to direct the removal of an assisted outpatient who is present in his or her county to an appropriate hospital, in accordance with the provisions of this subdivision, based upon a determination of the appropriate director of community services directing the removal of such assisted outpatient pursuant to this subdivision. Such person may be retained for observation, care and treatment and further examination in the hospital for up to seventy-two hours to permit a physician to determine whether such person has a mental illness and is in need of involuntary care and treatment in a hospital pursuant to the provisions of this article. Any continued involuntary retention in such hospital beyond the initial seventy-two hour period shall be in accordance with the provisions of this article relating to the involuntary admission and retention of a person. If at any time during the seventy-two hour period the person is determined not to meet the involuntary admission and retention provisions of this article, and does not agree to stay in the hospital as a voluntary or informal patient, he or she must be released.

- New York's Section 9.60(p) contains a provision authorizing prosecution for "false petition". HB 198 does not provide a criminal penalty for making a false statement or

providing false information or false testimony in a petition or hearing for AOT.

- New York's Section 9.60(r)(1) and (2) provide for both the preparation of educational and training materials, and the establishment of a training program for judges and court personnel, which shall focus on the use of the law and generally address issues relating to mental illness and mental health treatment. HB 198, Section 15, requires the preparation of educational and training materials but does not require the establishment of a training program for judges and court personnel.

III. Community resources

A. Availability

As mentioned above, in "Substantive Issues," Section II.A, there is a question whether any municipality or community or geographical area in New Mexico could coordinate, with the rapidity required under the proposed law, the services necessary to create a successful AOT plan for a respondent. Section 6(H)(2) of the bill contemplates that the respondent will have access to, and the availability of, recommended AOT "in the community or elsewhere". Does this mean that HB 198 contemplates the relocation of a respondent to receive necessary and recommended services, the temporary transportation of a respondent to receive necessary and recommended services – at whose expense? – and/or the receipt of services through telemedicine or other electronic means? (Again, at whose expense and to what degree of adequacy?) It has been noted that New York did not enact Kendra's Law prior to the creation of or consolidation of AOT programs and services, and that there was an infusion of new services accompanying implementation. (See *Disability Rights NM Presentation, Joint Meeting of the Court, Corrections and Justice Comm. and Legislative Health and Human Services Comm.*, http://www.nmlegis.gov/lcs/handouts/CCJ%20080614%20Item%201%20%20Nancy%20Koenigsberg,%20DRNM%20%20Assisted%20Outpatient%20Mental%20Health%20Treatment.pdf, August 6, 2014.) HB 198 does not provide for delayed implementation of the law subsequent to the creation of or consolidation of required AOT programs and services, nor does it request the institution of a pilot program or programs that would test the ability of communities and institutions and providers and qualified professionals and courts to plan for, create, consolidate, accept and make possible the provision of required AOT programs and services.

Additionally, there are questions concerning the availability of a full range of necessary services to those in rural areas of New Mexico and to those who are not already receiving services paid for by private insurance, as there is concern that essential services will not be covered by Medicaid.

B. Diversion

Advocates note that the diversion of community services through court-ordered outpatient treatment to those in need of AOT leads to positive outcomes and results. Other advocates state that there is no evidence to support the notion that court-supported coercion to receive treatment is an effective community solution to keep both those in need of AOT and their communities safe. (And some of those advocates argue that it is only the very rare case that the mentally ill pose a danger to others, although those cases are sensationalized in the media.)

The institution of AOT will more than likely divert community services away from others in need of those same services. Some argue that a more equitable – and, some say, equally effective – method of distribution of services for the mentally ill is to make all of the AOT services contemplated to be offered in the bill available to the community on a voluntary basis.
(For contrasting views on the need for and effectiveness of AOT programs and services, See

http://www.treatmentadvocacycenter.org/solution/assisted-outpatient-treatment-laws and http://www.disabilityrightsca.org/legislature/Legislation/2012/2012_04_15_AB%201569%20-%20Talking%20Points__2.html)

IV. Other Legislative and Policy Efforts

Senate Joint Memorial 4 was passed by the legislature during the 2015 legislative session, requiring the convening and reporting of a task force to study appropriate housing for the serious mentally ill who are in custody. The SJM 4 Task Force reported to the legislature in December. (See SJM 4 Task Force Final Report @ http://www.nmcounties.org/wp-content/uploads/2015/12/SJM-4-Report.pdf) The report recommends judicial, court personnel, provider and community education on mental health issues and the mentally ill. Additionally, the report recommends an improved, online, consistently-revised listing of community services and providers, as well as ways to make services technologically available to those in rural areas of New Mexico, and the institution and creation of regional facilities where necessary services may be housed – facilities that might be ideal locations for AOT teams that would allow for a successful implementation of AOT treatment statewide.

On top of statewide initiatives and developments, U.S. Sen. John Cornyn (R-TX) on August 5th, 2015 introduced the Mental Health and Safe Communities Act of 2015, which enhances and reauthorizes programs that promote collaboration between federal, state and local criminal justice systems to improve responses to people with mental illnesses. According to the Council of State Governments Justice Center

> The Mental Health and Safe Communities Act of 2015 is designed to improve outcomes for people with mental health disorders that come in contact with the criminal justice system through a number of actions, including:
>
> - The authorization of pretrial screening, assessment, and supervision programs to improve outcomes for people with mental illnesses by ensuring they are accurately diagnosed and receive appropriate need-based treatment that focuses on increasing public safety;
> - An increase in the use of treatment-based alternatives to incarceration for people with mental illnesses;
> - The establishment of a pilot program to determine the effectiveness of diverting eligible offenders from federal prosecution, federal probation, or a federal corrections facility, and placing those eligible people in drug or mental health courts;
> - Improvements to reentry programming for people with mental illnesses who are released into the community by authorizing the deployment of Forensic Assertive Community Treatment (FACT) Initiatives, which are designed to ensure that people with mental illnesses receive treatment-based interventions;
> - The expansion of specialized law enforcement crisis intervention teams, which respond to and de-escalate mental health crises for federal law enforcement personnel.
>
> https://csgjusticecenter.org/jc/announcements/u-s-sen-cornyn-introduces-mental-health-and-safe-communities-act/

It is anticipated that federal grant money may become available to the states for supporting

programs, including initiatives designed to ensure that people with mental illnesses receive treatment-based interventions, as listed above.

Thus, on both the state and federal levels, initiatives and legislation, still developing, may bring needed education, awareness, access to services and funding to the mental health realm, making it a prudent decision to delay or phase-in AOT throughout New Mexico.

ALTERNATIVES

1) Allow for delayed implementation of AOT until necessary services and support become available statewide.

2) Create a pilot program or programs in both rural and urban areas of New Mexico that would test the ability of communities and institutions, providers, qualified professionals and courts to plan for, create, consolidate, accept and make possible the provision of required AOT programs and services.

3) Work toward making the services available under AOT available in communities on a voluntary basis and study the effects of such effort.

4) Study the issue and plan for the availability of AOT teams and supporting institutions and providers statewide, while permitting existing statewide and federal efforts to develop and be in support of AOT efforts.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Status quo.

AMENDMENTS

See “Significant Issues” and “Substantive Issues,” above, for possible amendments.