A REPORT BY THE NEW YORK STATE OFFICE OF THE STATE COMPTROLLER

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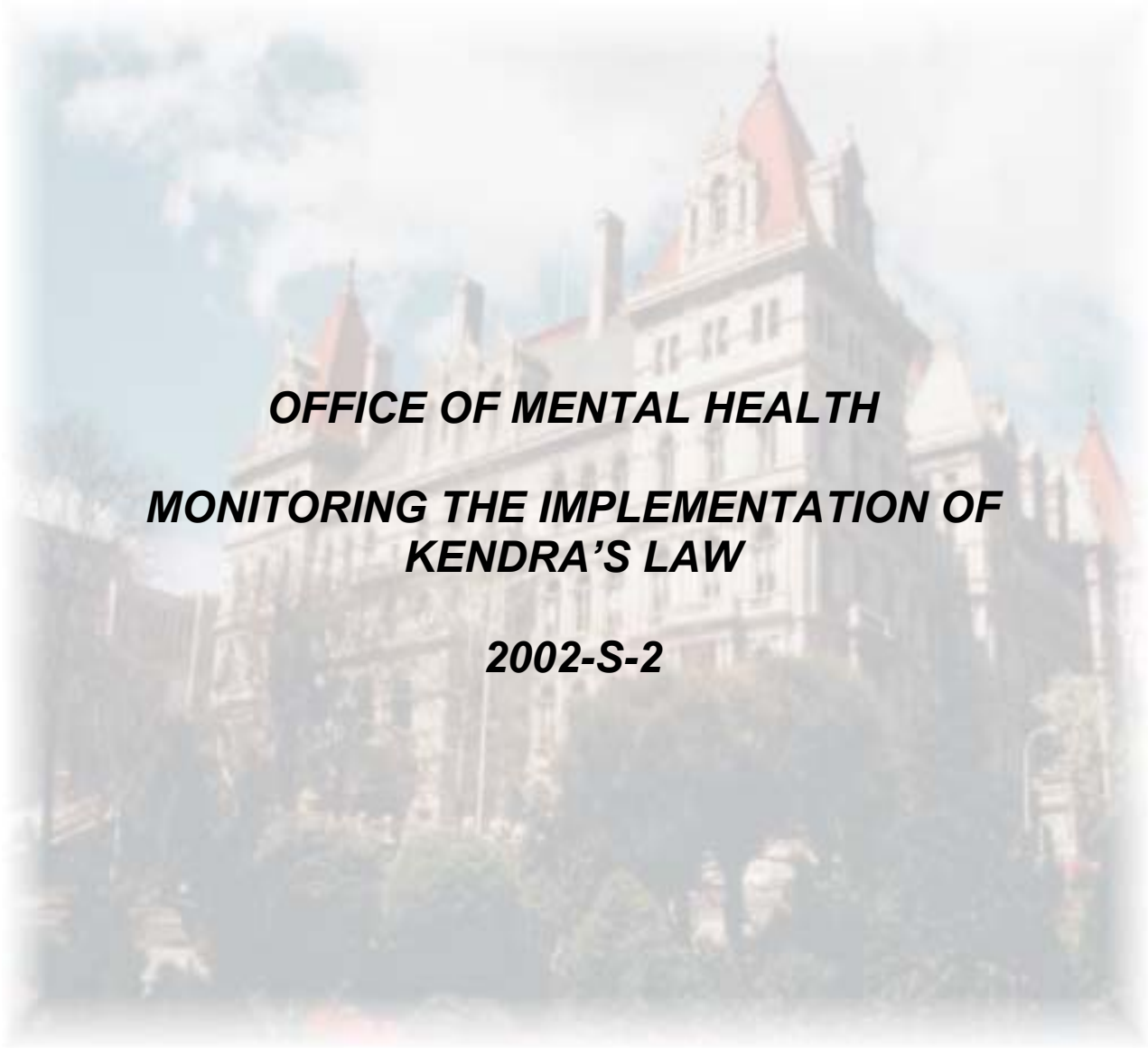

OFFICE OF MENTAL HEALTH

MONITORING THE IMPLEMENTATION OF KENDRA'S LAW

2002-S-2

DIVISION OF STATE SERVICES

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Report 2002-S-2

Sharon Carpinello, R.N., Ph.D.
Acting Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12237

Dear Dr. Carpinello:

The following is our report on the Office of Mental Health's Monitoring of the Implementation of Kendra's Law.

We performed this audit 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 list major contributors to this report in Appendix A.

Office of the State Comptroller
Division of State Services

June 24, 2004

EXECUTIVE SUMMARY

OFFICE OF MENTAL HEALTH
MONITORING THE IMPLEMENTATION OF KENDRA'S LAW

SCOPE OF AUDIT

The New York State Legislature enacted Kendra's Law (Law) in 1999 to provide assisted outpatient treatment (AOT) for mentally ill persons in the community who need to receive treatment to avoid harming themselves or others. The Law establishes procedures for obtaining court orders to require such persons to receive AOT services as prescribed in a written treatment plan. Although counties provide for the delivery of treatment services, the Law requires the Office of Mental Health (OMH) to approve all AOT programs and to monitor their operation to make sure clients receive the treatment provided for in the court orders. OMH has assigned 22 staff, including 5 AOT program coordinators, in 5 OMH field offices statewide, and has an AOT Central Office component whose primary function is to evaluate the program's success.

Most initial AOT court orders are for six months, but they can be extended for periods of up to one year. Client case managers are required to submit reports to OMH field offices that indicate a client's status at intake, describe client progress throughout the order, and sum up a client's experience in the program. Case managers also report on significant events that occur during the order, such as a client's hospitalization or noncompliance with treatment. OMH has developed two separate automated databases for AOT cases: Tracking AOT Cases and Treatment (TACT) and the Evaluation System. Although Central Office can use both systems, field offices have access only to TACT. OMH reports that 2,866 AOT cases were initiated from the program's inception to May 1, 2003.

For the period November 1, 1999 through May 15, 2003, our audit addressed the following question about OMH monitoring of the Law's implementation:

- Does OMH effectively monitor the AOT program to help ensure AOT clients receive the court-ordered treatment they need to live safely in the community?

AUDIT OBSERVATIONS AND CONCLUSIONS

Overseeing the individual counties' development and implementation of the programming necessary to satisfy the objectives of Kendra's Law represented a major undertaking for OMH, which OMH sucessfully accomplished. However, we found that OMH oversight could be improved to provide increased assurance that AOT clients follow the court-ordered treatment they need to reduce the risk of harm to themselves or others. To make sure AOT clients receive the supervised treatment the Law was enacted to provide, OMH should verify that case managers plan, coordinate and oversee the provision of services, and ensure that client information on OMH databases is accurate, complete and up-to-date. OMH should also give its field offices access to the Evaluation System to enhance their monitoring capabilities.

The Law makes OMH responsible for overseeing the operations of counties that administer the AOT program to make sure county program offices manage client cases properly and comply with OMH reporting requirements. However, our tests of 65 AOT cases at four local mental health offices revealed that program coordinators in OMH field offices do not have adequate information about AOT clients and their progress in the program to determine whether county offices are delivering court-ordered AOT treatment services. For example, field offices do not independently verify that treatment services reported were actually provided to clients. Further, field offices do not always confirm that case managers have submitted client progress reports, or review the reports that are submitted. New York City, with 80 percent of the State's AOT caseload, does not even receive these reports. We also found that TACT contains unreliable data: TACT entries for 61 of the 65 cases in our sample contained errors and discrepancies; other data, such as court orders, treatment information and significant events, was sometimes missing. The incomplete nature of TACT data is due, in part, to a design limitation that does not allow for entry of client progress data. Since field offices cannot access the Evaluation System that does contain this information, program coordinators cannot determine how well AOT is working for individual clients or localities. To help ensure clients receive the treatment they require to live safely in the community, we recommend that OMH verify that treatment services are received, take steps to improve the accuracy and completeness of TACT data, and give field offices access to the Evaluation System. (See pp. 16-24)

Central Office staff input client progress and treatment data from case manager reports into the Evaluation System. Central Office uses Evaluation System data to evaluate the AOT program's performance statewide. However, we found the system's data could be more complete, current and accurate. For example, of the 289 case manager reports that should have been entered in the system for our sampled cases, we found that: 47 reports could not be located; 209 reports contained errors or omissions, as submitted; and 167 reports had not yet been input. Of the 167 reports awaiting input, 79 were over one year past due for data

entry. We recommend that OMH update its client progress information promptly, verify data accuracy before entering it on the Evaluation System, and explore ways to share client progress data with field offices and localities to improve the supervision of AOT's high-risk client population. (See pp. 24-28)

COMMENTS OF OFFICIALS

OMH officials generally agreed with the report's recommendations and indicated actions taken or planned to implement them. OMH officials also stated their disagreement with our interpretation of their monitoring and oversight responsibilities for AOT programs. A complete copy of OMH's response is included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters of disagreement included in OMH's response.

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INTRODUCTION

Background

In August 1999, New York State enacted legislation amending the Mental Hygiene Law, commonly referred to as Kendra's Law (Law), to provide assisted outpatient treatment (AOT) for certain mentally ill persons living in the community. According to the legislative findings on which the Law was based, some mentally ill persons who live in the community could relapse and become violent, suicidal or require hospitalization if they do not receive the proper care and treatment. Kendra Webdale, the young woman for whom the Law is named, was pushed in front of a New York City subway train by a person who failed to take the medication prescribed for his mental illness.

The Law addresses this risk by establishing a procedure for obtaining court orders directing that certain mentally ill persons receive AOT services. AOT treatment services are prescribed in a written treatment plan prepared by a physician who has examined the person. If it is determined, after a hearing, that a person meets the criteria for AOT, the court issues an order to the subject of the petition (the client) and to the responsible county, to ensure that all court-ordered services are provided to the client. The Law provides for hospitalizing AOT clients who do not comply with treatment plans and pose a risk of harm. Although most initial court orders are for six months, they can be extended for successive periods of up to (and most typically) one year. The Law also required that the Commissioner of Mental Health approve all AOT programs, and that OMH designate State program coordinators to monitor and oversee AOT programs. Under the Director of AOT, there are 22 total staff including five AOT program coordinators. Each program coordinator is responsible for overseeing and monitoring counties' efforts in the geographical areas represented by the five OMH field offices statewide: New York City, Long Island, Hudson River, Central New York and Western New York. Thus, monitoring the Law's implementation is a responsibility OMH shares with local government.

Overseeing the individual counties' development and implementation of the programming necessary to satisfy the Law's objectives represented a major undertaking for OMH. To

establish the AOT program statewide, OMH developed and disseminated guidelines for implementing AOT programs throughout the State. Beginning in November 1999, counties created the mechanisms needed to implement AOT locally. OMH then developed policy and worked with numerous local mental health departments and offices to coordinate a wide range of AOT activities and services.

The initiation of AOT services begins when a court orders such services for a mentally ill client. The petitioner, who could be the director of the local AOT program, then assigns the client to a case manager who should provide structured oversight for the client. Outside New York City, counties or county-contracted providers (such as hospitals and group home operators) provide the case management services under the supervision of the local AOT program director. In New York City, the New York City Department of Health and Mental Hygiene, the local government entity responsible for supervising the AOT program in the five boroughs, contracts with the New York City Health and Hospitals Corporation (HHC) to provide AOT services. The City Department of Health and Mental Hygiene retains responsibility for ensuring that all services mandated by the court are provided.

Case managers are required to monitor the client's compliance with the treatment plan, and to report on the client's status by submitting Baseline, Quarterly and Follow-up Reports to the OMH program coordinators in their respective field offices or, for New York City cases, directly to OMH Central Office. The Baseline Report lists the client's demographic information and functional status at intake, and documents the services and medications, including those required by the court order. The Quarterly Report indicates the client's functioning in the program after three months, including problems such as hospitalization or noncompliance with the treatment plan. In the Follow-up Report, the case manager sums up the client's status at the end of the court-ordered treatment period. The case manager must also file a Significant Event Report with OMH, examples of which include instances where a client: is arrested or accused of a crime; commits a violent act against someone; or, could not be located for more than 24 hours. OMH's Procedures Manual for Reporting by Local Governmental Units (Manual) identifies filing deadlines for the above case manager reports.

Because about 80 percent of the AOT caseload is in New York City, 7 of the 22 OMH AOT staff work in the New York City Field Office, and between 2 and 4 staff work in the other 4 field offices. The directors of local AOT programs are supposed to send program coordinators information about every AOT order in their jurisdiction, and report on their overall AOT program operation. Program coordinators' responsibilities include monitoring to make sure AOT clients receive the services indicated in court-ordered treatment plans in a timely way. OMH has also developed a Central Office component for the AOT program. The AOT Project Director and four managers at Central Office work with the field office program coordinators, provide public education, collect and analyze data, and report on the results of the AOT program.

OMH has developed two separate automated databases related to AOT: Tracking AOT Cases and Treatment (TACT) and the Evaluation System. According to OMH officials, TACT is intended to serve as a "tool or memory aid" for field offices to help program coordinators follow the progress of AOT cases. Program coordinators enter client demographic and court decision data on TACT, as well as service and provider information and any significant events (such as a client's noncompliance with treatment, hospitalization, arrest, etc.) that occur. Both field offices and Central Office can access TACT data. The Evaluation System contains information from the Baseline, Quarterly and Follow-up Reports. Central Office personnel enter report data received from case managers on the Evaluation System to enable them to identify general trends and develop feedback on its success. Field office program coordinators cannot access the Evaluation System.

Of the 2,866 AOT cases OMH reports were initiated from program inception to May 1, 2003, 2,299 cases (80 percent) were initiated in New York City. Of the remaining 567 cases, 274 cases (10 percent) were initiated in the two counties under the jurisdiction of the Long Island Field Office, and 159 cases (5 percent) were initiated in the 16 counties under the jurisdiction of the Hudson River Field Office. The remaining 134 cases were initiated in either the Central New York or Western New York field offices.

Audit Scope, Objective and Methodology

We audited OMH's monitoring of the implementation of Kendra's Law for the period November 1, 1999 through May 15, 2003. The objective of our performance audit was to determine whether OMH effectively monitors the AOT program to help ensure AOT clients receive the court-ordered treatment they need to live safely in the community.

To accomplish our objective, we interviewed OMH officials from Central Office and four field offices (We did not interview officials from OMH's fifth field office because the population of AOT cases for this office was low in comparison to the other field offices.) and we reviewed applicable sections of the Mental Hygiene Law. In addition, we visited four of the 19 local mental health offices that are under the jurisdiction of the New York, Long Island and Hudson River field offices (Nassau, New York City, Rensselaer and Suffolk Counties), and selected a random sample of 65 AOT cases from the 2,866 AOT cases initiated from program inception to May 1, 2003. For each of the 65 AOT cases, we reviewed documentation to determine whether all pertinent materials, including court documents and written treatment plans, were submitted, reviewed and approved; and whether there was documentation to show services were provided as required. We also visited the three OMH field offices (New York City, Long Island and Hudson River) with oversight responsibility for the above local offices. Further, we reviewed selected data from TACT and the Evaluation System.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of OMH that are within our audit scope. Further, these standards require that we understand OMH's internal control structure and its compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities for audit. This approach focuses our audit efforts on those operations that we have identified through a preliminary survey as having the greatest probability of needing improvement. Consequently, by design, we use our finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

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, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under Generally Accepted Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

Response of OMH Officials to Audit

We provided draft copies of this report to OMH officials for their review and comment. Their comments have been considered in preparing this report, and are included as Appendix B. Appendix C contains State Comptroller's Notes, which address matters of disagreement included in OMH's response.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of OMH 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.

MONITORING THE IMPLEMENTATION OF KENDRA'S LAW

The Law was passed to reduce the risk that certain mentally ill persons in the community will endanger themselves or others because they do not follow prescribed treatment, including taking needed medication. The Law directs OMH to oversee the local administration of the AOT program. OMH oversight comprises program coordinators to monitor local case management, two separate automated databases, and Central Office efforts to analyze and report on the success of the AOT program. Pursuant to the Law, the Commissioner of OMH must appoint program coordinators, who are responsible for the oversight and monitoring of AOT programs. Working in conjunction with directors of community services of local governmental units, OMH's five program coordinators have the following specific responsibilities: 1) that each assisted outpatient receives the treatment provided for in the court order; 2) that existing services located in the assisted outpatient's community are utilized whenever practicable; 3) that a case manager or assertive community team is designated for each patient; 4) that a mechanism exists for each case manager or assertive community team to regularly report the assisted outpatient's compliance, or lack of compliance with treatment, to the director of the assisted outpatient treatment program; and, 5) that assisted outpatient treatment services are delivered in a timely manner.

We found that OMH has successfully overseen the implementation of local AOT programming. However, we also determined that OMH can improve its oversight and monitoring of the AOT program to provide increased assurance that each assisted outpatient receives the treatment provided for in the court order. Specifically, we found that OMH program coordinators do not verify that case managers provide client services; TACT, the only database field offices can access, contains client data that is not adequate for oversight purposes; and the Evaluation System, which was designed to help OMH identify general trends and determine the impact of AOT, could also be used for monitoring individual clients. Further, we found that client progress information is both inaccurate and outdated.

Our review of 65 AOT client cases revealed that OMH field offices, with responsibility for making sure clients receive their court-ordered treatment, did not adequately monitor clients' progress in treatment, and were often unaware of significant events that occurred, or how these events were handled by local AOT program offices. When oversight is ineffective, clients – particularly mentally ill clients at high risk of relapse – can fail to receive the treatment services they need to live safely in the community.

Field Office Monitoring

The Law states that field office program coordinators are responsible for overseeing local mental health organizations' administration of the AOT program to ensure court-ordered treatment is delivered, and provided in a timely manner. If program coordinators find that treatment services are not delivered timely, they must act to make sure local administrators correct the problem. We visited four local mental health offices (New York City, Nassau, Rensselaer and Suffolk) and three field offices (New York City, Long Island and Hudson River) to identify the steps program coordinators take to make sure local officials provide clients with treatment in a timely way. Our tests of a random sample of 65 case files (35 in New York City and 10 in each of the other county mental health offices we visited) found that program coordinators often do not know whether treatment is delivered because:

- they do not independently verify that treatment services were provided;
- they do not receive, or do not review, the Baseline, Quarterly and Follow-up reports of client progress produced by case managers;
- they rely on limited and sometimes inaccurate TACT data; and
- they do not always ensure significant events are reported in compliance with OMH requirements.

If corrected, these oversight weaknesses, which we discuss below, would result in more effective monitoring of a program that provides essential mental health services to this high-risk population.

Contacts with Local AOT Programs

The program coordinators in the three OMH field offices we visited said they maintain contact with local government units that directly supervise AOT case management through e-mail and telephone contact, at weekly and/or quarterly meetings and through periodic visits to local government AOT program offices. When we asked for evidence of informal contacts or notes of meeting discussions, we found little documentation to show that OMH program coordinators could use such contacts to ensure AOT clients received treatment services in a timely way.

For example, we found no documentation of verbal or e-mail communication, or any indication of the frequency of these contacts. Further, while New York City and Long Island officials told us they hold weekly meetings with county officials (Hudson River does not hold weekly meetings), there is no documentation to show these meetings have an impact on client monitoring. New York City officials report that they discuss problem cases during these meetings, and that meeting documentation consists of meeting minutes and meeting agendas. However, no one keeps the minutes, and we found the agendas of future meetings were not detailed enough to provide a basis for monitoring. Long Island officials said they discuss every current case during their weekly meetings. They told us they create summary meeting notes, compare these notes to documents of client progress, and make any needed changes in TACT. However, Long Island officials had no documentation of the results of their comparisons, and we could not substantiate the number and types of changes officials may have made in TACT because the database does not provide this kind of information. The quarterly meetings New York City and Hudson River officials have with county AOT officials do not involve discussions of specific cases, and are thus not effective for monitoring purposes.

Officials at each of the three field offices told us they periodically visit county AOT program offices. However, we found that field office officials do not check county records during these visits to make sure treatment services are being delivered in a timely manner. In fact, officials at all three field offices indicated that reviewing client records is not their responsibility. In New York City, officials explained that AOT is a county-run program monitored by the New York City Department of Health and Mental Hygiene, which, in turn, contracts monitoring duties to

the New York City Health and Hospitals Corporation (HHC). HHC does not review provider records to verify treatment either; instead, case managers send HHC weekly verbal or faxed comments that often contain only minimal information (e.g., "Patient is compliant."). Thus, New York City is two levels of review away from actual AOT cases.

Hudson River officials said they review the records of clients with problems during visits so they can provide insight to help address such issues. However, Hudson River officials do not document this review. Long Island officials told us each county in their jurisdiction has a mechanism in place to verify that clients receive services. However, when we reviewed documentation of Nassau County's verification process, we found that county case managers call providers weekly to inquire about services provided, but do not independently verify the contacts providers report. Periodic independent verification of the delivery of treatment services is essential if field offices are to ensure that provider reports are complete and accurate.

OMH officials state that OMH field office contacts with local AOT programs constitute a framework for program oversight that fulfills monitoring, technical assistance and quality assurance objectives. We agree OMH has established a framework for operating local AOT programs, and believe OMH should continue to provide technical assistance. However, now that this framework is established, it is essential that OMH routinely verify how well it works, and document how the verification was done.

Case Manager Reports

According to OMH's Manual, county AOT program offices must send case manager reports of a client's progress (i.e., the Baseline, Quarterly and Follow-up Reports) to program coordinators in their respective OMH field offices. Since the Law makes program coordinators responsible for making sure AOT clients receive treatment in a timely manner, review of these case manager reports would help program coordinators fulfill their monitoring function. However, we found the three field offices did minimal, if any, review of these reports.

For example, New York City has not received or reviewed these reports since September 2001 due to the volume of reports submitted. Instead, service providers send these reports

directly to Central Office, where Central Office personnel enter the information on the Evaluation System database. New York City officials review only the significant event sections of the Quarterly and Follow-up Reports that Central Office forwards to them. Hudson River officials report that they review only the "client status" information (e.g., hospitalized, incarcerated), but not other reported data, such as significant events, medication management, harmful behavior, etc. Hudson River officials do not document their review of these reports. Long Island officials told us they review the reports they receive, and make any needed changes in TACT, before sending the reports to Central Office for data entry. Again, however, field office officials do not document this review process. Long Island officials said they received comprehensive client progress reports from Suffolk during the first year of the AOT program's operation, but that Suffolk no longer submits such reports on a regular basis.

We also found that, because they do not review or rely on these reports, field offices do not ensure that all case manager reports due are actually received, are submitted in compliance with OMH timeframes, and are complete and accurate. The 65 clients in our random sample should have had a total of 289 reports submitted for their AOT cases as of October 31, 2002. Of that number, only 242 were available for review; 47 reports could not be located. Of the three offices we visited, only Long Island had a mechanism for determining whether all reports that were due were actually received. However, this control was not completely effective, since we identified two instances of missing reports at this office.

We also tested for the timeliness of submissions. The Manual requires that Baseline, Quarterly and Follow-up Reports be submitted within specific timeframes. Baseline Reports must be submitted within 30 days of the initial AOT order and within 30 days of the expiration of the final order. Follow-up Reports must be submitted within 30 days of the initial court order and at six month intervals thereafter. Quarterly Reports should be submitted within seven days of the end of the quarter reported on. However, we found that 42 of 242 reports were not submitted as required. Of the 42 reports, 33 were due in New York City, 7 in Long Island and 2 in Hudson River.

We also found errors and omissions in the case reports received at these offices. In examining the 242 available reports, we found 209 reports (85 percent) contained errors

ranging from blank or missing pages to services that did not match the services prescribed on court-ordered treatment plans. Of the 209 reports with errors, 110 were from New York City, 61 were from Long Island and 38 were from Hudson River. When we compared report information to other sources (such as case notes, when available; TACT entries; and Evaluation System entries), we found numerous instances of inconsistent information about the client, dates or types of service, or events that occurred. We believe these errors and inconsistencies go undetected – and uncorrected – because field offices do not review the reports they receive, or compare the information on the reports to other documents and sources to confirm it is complete and correct.

Significant Event Reports

OMH also requires that local AOT program offices report significant events that take place during a client's treatment period. The most serious significant events include incidents in which the client: is arrested or accused of a crime; commits an act of violence against another person; or cannot be located after 24 hours of search effort. These events must be reported to OMH in a Significant Event Report within 24 hours of their occurrence. Other less serious significant events, including noncompliance with treatment or hospitalization, can also be reported on the Significant Event Report as well as in aggregate on the Quarterly Report or Follow-up Report. Field offices are supposed to record on the TACT database any significant event that occurs throughout the duration of a client's AOT order.

However, when we examined the reporting of significant events related to the 65 AOT clients in our sample, we found that some significant events were not reported properly, or not reported at all; other significant events were reported inconsistently, or later than the timeframes require. For example, the Long Island office accepts verbal reporting of events that require a formal report within 24 hours of the event. Although Long Island officials told us county offices had sent 20 written significant event reports directly to Central Office, Central Office officials said they did not receive the 8 reports due from Nassau and the 12 reports due from Suffolk. When discussing this discrepancy with Long Island officials, they stated they were unaware of the OMH requirement to report certain serious significant events within 24 hours.

We also tested to determine whether significant events were reported properly and consistently by comparing the following sources of information: Significant Event Reports; significant events reported on the Quarterly Reports and Follow-up Reports; entries on TACT; and available case progress notes. We identified serious inconsistencies in the number of events reported between the four sources. Of the 407 events that fit the definition of a significant event for the 65 sampled clients, 51 events were not reported to OMH; (38 from New York City; 8 from Hudson River; and 5 from Long Island). The 356 significant events that were submitted to OMH were reported inconsistently and in a wide variety of ways. Sometimes they appeared in just one of our sources, and sometimes reports of the same type of event appeared in two or three sources.

To illustrate with one field office's reporting of significant events, we identified 184 significant events for our sample of 35 cases from New York City. To determine whether all the significant events for these cases were reported to OMH, we compared information for these cases as reported in Significant Event Reports; on TACT; on comprehensive client progress reports; and on Quarterly and Follow-Up Reports. Of the 184 events, we found that 38 events were not reported to OMH at all; the remaining 146 significant events were reported by variety of means, as follows:

- 15 were described in significant event reports only;
- 18 were reported only on TACT;
- 98 were included in Quarterly or Follow-up Reports;
- 6 were reported on TACT and in significant event reports;
- 1 was reported in Significant Event, Quarterly and Follow-up Reports;
- 6 were included in TACT and on Quarterly and Follow-up Reports; and
- 2 were reported in TACT, Significant Event, Quarterly and Follow-up Reports.

We also found that almost all the serious significant events involving our 65 sampled clients were reported late. Of the 82 significant events that were required to be reported to OMH within 24 hours, we could confirm that only 2 were received within this timeframe. We could not verify the reporting date for the other 80 cases.

Significant event data goes unreported, or is reported inconsistently in different information sources, because field offices do not compare the information about significant events in the Quarterly and Follow-Up Reports, the Significant Event Reports, and TACT to ensure they have accurate accounts of significant events for AOT clients.

Using the TACT Database

TACT is a database system that tracks AOT clients for whom court-ordered treatment has been prescribed. At field offices, program coordinators enter specific case information in TACT, such as client demographic data, the court decision, treatment service and provider information, and any significant events that occur during the duration of the AOT court order. Central Office also has access to TACT so it can obtain feedback on the effectiveness of the AOT program. On reviewing TACT data, we identified inaccurate and incomplete information, in part because of data entry errors or omissions and in part because of database design limitations.

We tested the reliability of TACT data by reviewing information on TACT for our sample of 65 AOT cases. We compared information on TACT to source documents, such as Baseline, Quarterly and Follow-up Reports, Significant Event Reports and case management notes, where available. We found errors and discrepancies in 61 of the 65 cases, including 6 instances in which the AOT team responsible for individual AOT clients was incorrectly identified; 11 instances where clients' status (e.g., hospitalized) was reported incorrectly; 22 instances where events were dated differently on TACT and in case management notes; and duplicate entries of one client's data: one entry with a correctly spelled surname, and a second entry with a misspelled surname.

We also found that TACT data was incomplete. Sometimes the data was incomplete because TACT entries were simply not made. For example, in testing our sampled cases, we found 3 instances in which a court order was not recorded on TACT; 26 instances in which events were missing event dates (e.g., case initiated, investigation concluded, petition filed, order terminated); 6 instances in which treatment data was missing or incomplete; and 251 of the 407 significant events we identified for our sample were not recorded. In one case, TACT identified only 2 of the 35 significant events listed on the Follow-up Report

done at the end of one client's treatment period. TACT had no data on the following 33 events that occurred during the 6-month court order:

- 14 instances of substance abuse problems;
- 14 instances of reported serious non-compliance with court ordered treatment;
- 4 instances where 911 was called; and
- 1 instance in which the client was still missing after 24 hours search.

Thus, the field office, with a mandated responsibility to oversee AOT operations, had no information about a whole series of client activities, any one of which could have resulted in harm to the client or someone else. It is essential that field offices verify the accuracy of the data they enter in TACT, keep client information current, and record all client significant events.

However, we also found that TACT data was incomplete because the database is not designed to include the critical information about client progress contained in case manager reports. For example, while TACT does contain most of the data included in the client's Baseline Report, it does not have fields to enter client treatment data from the Quarterly Reports, such as the client's progress in receiving prescribed services, the medication(s) they receive, and their compliance with the treatment plan. The Hudson River and Long Island field offices receive the Quarterly and other case manager reports, as the Manual requires. However, according to statements made to us by Hudson River and Long Island field office officials, these offices do little if any review of the reports before they forward them to Central Office. TACT has no provision for client progress entries, even if these offices wanted to maintain such information. However, the New York City Field Office, with responsibility for monitoring 80 percent of the State's AOT caseload, does not receive the case manager reports at all. Instead, individual case managers send their reports directly to Central Office for entry in OMH's Evaluation System. Central Office personnel enter client progress information from all clients statewide in OMH's Evaluation System. OMH uses this data to measure the success of the AOT program on a global scale. However, field offices have access only to TACT, and cannot access the Evaluation System. This means that OMH program coordinators with responsibility for ensuring that each

AOT client receives the treatment provided for in the court order are not fully equipped to do it.

Further, although field offices can use TACT to record significant events that occur, they cannot indicate on TACT the duration of an event, such as hospitalization or incarceration. For example, one of our sampled clients was hospitalized for the majority of the duration of the court order (five of the six months), but the TACT record showed one instance of hospitalization. Another sampled client who was hospitalized eight times, each time for a few days, was reported as having been hospitalized eight times. The latter client would appear, on TACT records, to be in higher need of AOT services than the former client, whose condition would not even allow living in the community for most of the court order.

The Law was enacted to provide close local supervision of AOT clients so they can live safely in the community, and field offices are mandated to oversee the provision of AOT treatment services. To be able to effectively monitor the AOT program, field offices must have access to client progress data to help ensure that AOT clients are receiving the services identified in the court order.

OMH officials indicated that TACT is intended to be a memory aid for OMH program coordinators, not a monitoring tool. Thus, errors and discrepancies in TACT data do not indicate a poor job of monitoring. Officials state that OMH accomplishes its real monitoring through technical assistance and quality improvement contacts with county AOT program directors. In our view, a “memory aid” replete with information lapses and errors is of little use for any purpose. Further, OMH acknowledges that program coordinators are master-level professionals whose duties include overseeing and monitoring care provided to persons under AOT. To carry out this mandated responsibility, these professionals need accurate and current information about AOT clients, such as medications, treatment data, and significant events that occur during the order period.

Central Office Monitoring

Central Office regularly contacts field offices through weekly phone calls, training arrangements, quarterly meetings and periodic visits. Central Office monitoring focuses primarily on

the performance of the AOT program statewide, and the tasks related to performance reporting, such as database maintenance, data analysis and public education. OMH relies on the Evaluation System to understand overall trends and outcomes associated with AOT service delivery statewide. However, we found it takes Central Office almost five months to enter case manager report data in the Evaluation System, and that 74 percent of the case data on the system for our sampled cases contained errors. OMH should update its client progress information promptly and manage the client data it collects more productively.

The Evaluation System comprises four databases: the Baseline, Quarterly, Follow-Up and Tracking databases. The first three databases capture the information from the case manager reports of the same name. The Tracking database contains processing and compliance data related to the management of each client's case, such as report due dates, report receipt dates, problems or notes, and whether a report has been entered in the Evaluation System. The date a report was entered in the system can be found on the source documents (i.e., the case manager reports).

We tested the accuracy and completeness of the AOT client data on the Evaluation System in the same way we tested TACT: by reviewing client status and treatment information related to our 65 sampled AOT clients. Based on the results of this test, we concluded that client information on the Evaluation System could be more current and comprehensive. For example, we determined that 289 case manager reports were due, collectively, for the 65 cases in our sample as of October 31, 2002. However, we found that, of the 289 reports due, Central Office could not locate 47 reports (16 percent). Of the 242 remaining reports, only 75 reports had been entered in the Evaluation System. The remaining 167 reports (69 percent) had not been entered in the system as of March 11, 2003 (the date of our audit test), over 4 months after the most current report was due. Using this date as our basis for calculation, we determined the backlog ranged from 130 days (4.3 months) to 980 days (more than 2.5 years); 79 reports were over one year past due for data entry.

On average, it takes 148 days (5 months) from the date Central Office receives a report until personnel enter the report in the Evaluation System. Since reports are often received late, this

average time it takes for client data to appear on the Evaluation System increases to 317 days compared to the actual due date of the report. We attribute the backlog in report entries to, among other things, the lack of timeframe requirements for entering report data, and an absence of policy about how to prioritize data entry tasks to reduce the backlog.

We also found that Evaluation System data could be more accurate and reliable. As noted earlier in this report, we identified errors, ranging from missing pages to services that did not match treatment plans, in 209 of the 242 (86 percent) available case manager reports, as submitted to Central Office. In addition to these errors in source documents, we also found that Central Office personnel made errors in entering the data. We compared the data in 68 of the 75 reports that had been entered in the Evaluation System for our sampled clients to source documentation (Central Office could not provide reports for the remaining 7 reports). We found that the Evaluation System data did not match hard-copy report data for 50 of the 68 reports (74 percent) we reviewed.

In responding to our preliminary audit findings, OMH officials stated that OMH is not required by Law to collect detailed information on individual clients, but that it does so to conduct statistical analyses of the program's impact on the population served by the program statewide. Since OMH does collect this data, it should be as accurate as possible to enable a proper assessment of program outcomes. Collected data should also be shared with field offices, so they can be knowledgeable about AOT program results for both the entire AOT population, and for the individuals who make up this population.

The Evaluation System was not designed to be a monitoring tool. However, OMH could use information from the system to monitor client status and progress, provided that OMH corrects the data accuracy and data entry delay problems we identified. For example, since OMH captures all reports from all AOT patients, Central Office could generate reports on statistics by county, by region or by individual. The Evaluation System could produce reports showing patterns and trends throughout the State, region or county, and characteristics common among AOT candidates. Although OMH officials, in their response, indicated that they already take these steps, we did not see any evidence of such information-sharing during our audit.

We believe that distributing reports beyond Central Office can enhance the field offices' ability to monitor local AOT programs. Central Office officials told us that no field office has requested any reports from the Evaluation System. However, field offices have never had access to Evaluation System data, so they may not be aware of the breadth of information about client progress and local program compliance the Evaluation System could provide to them. In responding to our preliminary audit finding on this matter, OMH stated that it does share information with field office personnel as well as local AOT staff. Again, we did not see any evidence of this sharing during our audit.

OMH, by taking steps to improve the timeliness and accuracy of information maintained on the Evaluation System, could improve its oversight efforts and provide valuable information to local authorities. This would also facilitate efforts to ensure that AOT clients receive case management and treatment services they need.

Recommendations

1. Improve field office oversight and monitoring activities by:
   - implementing procedures to determine that all required reports are provided;
   - periodically verifying that services claimed to have been provided to AOT clients were, in fact, provided;
   - documenting any contacts made regarding AOT clients; and
   - enforcing requirements pertaining to the reporting of significant events.

2. Periodically verify the accuracy and completeness of data entered on TACT and the Evaluation System. At a minimum, this verification process should include a comparison of client information sources to information entered in both systems and the correction of errors, discrepancies or missing information.

3. Explore the feasibility of including data about AOT client medications and the duration of any client hospitalization or incarceration that occurs on TACT.

4. To the extent possible, provide field offices and counties with on-line access to the Evaluation System.

Recommendations (Cont'd)

5. Develop guidelines that state timeframes for entry of case manager reports on the Evaluation System, and take steps to reduce the backlog of reports awaiting entry in the system.

6. Provide OMH field offices with information about the capabilities of the Evaluation System. Explore new ways of using the client information collected to help field offices and local program offices ensure AOT clients receive court-ordered treatment services.

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January 12, 2004

Kevin McClune
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State Audit Bureau, 11th Floor
Office of the State Comptroller
110 State Street
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Dear Mr. McClune:

The Office of Mental Health has reviewed the draft audit report entitled, Monitoring of the Implementation of Kendra's Law (2002-S-2). Our comments to the findings and recommendations contained in the report are enclosed.

The Office of Mental Health appreciates the Office of the State Comptroller's efforts to recommend improvements in our operations.

Many thanks for your continued help and cooperation.

Sincerely yours,

Sharon E. Carpinello, RN, Ph.D.
Acting Commissioner

Enclosure

OFFICE OF MENTAL HEALTH
RESPONSE TO OFFICE OF THE STATE COMPTROLLER
DRAFT AUDIT REPORT 2002-S-2
MONITORING THE IMPLEMENTATION OF KENDRA'S LAW

Overall OMH Comments

The Office of Mental Health concurs with the conclusion reached by the Office of the State Comptroller in the Executive Summary, which states in part, *"Overseeing the individual counties' development and implementation of the program necessary to satisfy the objectives of Kendra's Law represented a major undertaking for OMH, which OMH successfully accomplished."* OMH's challenge was to assist counties in implementing the legislation in only 90 days from the date it was signed into law.

OMH takes pride in what has been accomplished to date relating to Kendra's Law and Assisted Outpatient Treatment (AOT). The agency has gone beyond the statutorily-mandated work prescribed in Mental Hygiene Law Section 9.60. In addition to tracking AOT cases to ensure timely provision of court-mandated services, OMH has chosen to collect data on individuals under AOT Orders for evaluation purposes. The data collected have been and will continue to be instrumental in: (a) determining the effectiveness of AOT for seriously and persistently mentally ill individuals; (b) assessing the strengths and weaknesses of the program; and (c) assisting counties in optimizing programs in their effort to assist people suffering from mental illness to live safely and successfully in the community. Data collection is likewise used in furtherance of quality improvement.

As a result of such data collection, OMH has shown that people under AOT Orders have: an increased participation in case management and other services; a reduced incidence of hospitalizations, homelessness, arrests and incarcerations; an increased engagement in services and adherence to prescribed medications; an improved community and social functioning; and a decreased incidence in harmful behaviors.

Although we differ with OSC on the interpretation of OMH's monitoring and oversight responsibilities, OMH has reviewed and considered each recommendation made by OSC. From that review, we have chosen to adopt several processes in an effort to improve our already well-functioning system. These new processes are discussed in response to OSC's six audit recommendations, and in the following OMH comments to OSC statements in various sections of the draft report.

Finally, Attachment A provides an appropriate context in which the reader can assess the adequacy of OMH's oversight and monitoring efforts in timely implementing Kendra's Law. Sections I through III of Attachment A, include: AOT Program Implementation and OMH Oversight; the Impact of AOT on Local Mental Health Systems; and AOT Program Outcomes.

OMH Response to OSC Recommendations

OSC Recommendation No. 1 – Improve field office oversight and monitoring activities by:

- **implementing procedures to determine that all required reports are provided;**

OMH Response: Staff responsible for evaluation data have recently developed a system by which individual rosters are sent out monthly to each case management and Assertive Community Treatment (ACT) provider indicating which assessments are coming due and which are overdue. Field offices are provided with corresponding rosters for providers in their regions. Field office staff follow-up by phone and at monthly meetings to ensure that all assessments are completed and forwarded to OMH in a timely manner.

- **periodically verifying that services claimed to have been provided to AOT clients were, in fact, provided;**

OMH Response: In collaboration with the responsible county, the following approachs will be employed as mechanisms for ensuring and verifying timely provision of court-ordered services:

a) 'ride-alongs' with case management or ACT staff to witness provision of services to clients;

b) visits to treatment programs for the purpose of verifying provision of services; and

c) reviews of paid Medicaid claim data.

In addition, OMH Licensing and Certification staff will incorporate into visits to licensed outpatient programs a review of the medical records of persons being serviced under an AOT court order.

- **documenting contacts made to AOT clients; and**

OMH Response: As direct contact with clients is not an OMH monitoring responsibility, this recommendation is not applicable to OMH.

* Note 1

- **enforcing requirements pertaining to the reporting of significant events.**

OMH Response: A monthly reminder mechanism has been in effect, and continues to be in effect. to reinforce with case management and ACT staff the importance of reporting significant events. Additionally, OMH now requires each county to complete a Quarterly Report, which includes cumulative information regarding significant events for each AOT client. This county summary is

* See State Comptroller's Notes, page 41

used to verify the accuracy and completeness of the individual reports from the case management and ACT agencies, as well as ensuring county oversight of persons receiving AOT.

OSC Recommendation No. 2 – Periodically verify the accuracy and completeness of data entered on TACT and the Evaluation System. At a minimum, this verification process should include a comparison of client information sources with information entered in both systems and the correction of errors, discrepancies or missing information.

OMH Response: OSC's identification of "errors and discrepancies" in TACT is in fact evidence of a fluid system in which updates (not corrections) are entered as new information is learned/obtained. Monthly meetings with county AOT leadership are used to discuss and to add the TACT changes that were not immediately reported to OMH in the treatment status or living situation of AOT clients.

* Note 2

It should be noted that the Evaluation System exists for the purpose of reviewing the overall AOT program, and not for tracking individual cases. Moreover, OMH is considering the feasibility of combining the Evaluation System and TACT databases. This would provide Program Coordinators with another method to verify data.

Recommendation No. 3 – Explore the feasibility of including data about AOT client medications and the duration of any client hospitalization or incarceration that occurs on TACT.

OMH Response: It is not feasible to maintain up-to-date information about medications in TACT. AOT clients are often prescribed multiple medications, which can appropriately change with some frequency as the client's physician attempts to find the optimal combination to minimize symptoms and side effects and to maximize effectiveness and compliance. Maintaining up-to-date knowledge of each client's particular combination of prescribed medications is a clinical function and is not one that OMH is charged to oversee.

The new TACT system (TACT II) provides for entry of information on the duration of hospitalizations and incarcerations and this data is entered as it is received from counties and providers.

OSC Recommendation No. 4 – To the extent possible, provide field offices and counties with on-line access to the Evaluation System.

OMH Response: As mentioned in response to Recommendation No. 2, OMH plans to provide field offices with electronic access to the evaluation data being collected on all clients under AOT Orders. Authorized AOT staff will then be able to cross-check assessments to TACT information.

* See State Comptroller's Notes, page 41

Counties and local providers providing services to AOT recipients will also have access to the evaluation data.

OSC Recommendation No. 5 – Develop guidelines that state time frames for entry of case manager reports on the Evaluation System, and take steps to reduce the backlog of reports awaiting entry in the system.

OMH Response: See OMH response to Recommendation No.1. Additionally, OMH has instituted mechanisms to closely monitor the volume of data received to ensure that data are entered into the Evaluation System in a timely way. These mechanisms have resulted in the virtual elimination of any data entry backlog.

OSC Recommendation No. 6 – Provide OMH field offices with information about the capabilities of the Evaluation System. Explore new ways of using the client information collected to help field offices and local program offices ensure AOT clients receive court-ordered treatment services.

OMH Response: Please refer to OMH responses to Recommendation Nos. 2 and 4.

OMH Comments to Statements in OSC Report Sections

This section addresses OSC statements throughout the report which require clarification or are incorrect. The page number and paragraph of the OSC draft report are noted in *italics*, immediately following OMH's comments.

Introduction

- The court issues its order to the subject of the petition (the client) and to the responsible county to ensure that all court-ordered services are provided to the client. The court does not issue orders to the director of a hospital licensed or operated by OMH, as OSC contends. Likewise, the court does not necessarily issue an order to the petitioner, unless the petitioner is the county. *(Page 1, Paragraph 2, third sentence)*

  * Note 3

- Health and Hospitals Corporation (HHC) is not responsible for ensuring provision of all services for AOT clients in New York City. The City retains responsibility for ensuring that all services mandated by the court are provided. *(Page 2, Paragraph 2, last sentence)*

  * Note 3

* See State Comptroller's Notes, page 41

Field Office Monitoring

OMH does not agree with OSC's **Field Office Monitoring** section and, more particularly, with the four bullets on Page 7. Field office staff do: (1) monitor provision of treatment services by interfacing regularly with county leadership responsible for AOT; (2) either receive and review Baseline, Quarterly, and Follow-Up Assessments or, receive and review all cumulative reports of significant events and all narratives contained in those assessments; (3) rely on accurate information which is provided by case managers and other AOT staff; and (4) address the issue of late or missing Significant Event Reports with the counties on a regular basis.

* Note 4

Contacts with Local AOT Programs

OMH also disagrees with OSC's position that a lack of minutes kept on routine weekly meetings with counties (usually "one-on-one" meetings) about their AOT practices raises doubts as to whether such meetings could be used to monitor timely receipt of court-ordered services. In New York City, for example, these meetings are one-on-one with agendas prepared by OMH staff prior to each meeting. Meetings with two people present do not warrant minute-taking, therefore, the succession of agendas from one week to the next serve as memorialization of the concerns requiring attention. *(Pages 8 and 9)*

* Note 5

Case Manager Reports

- OSC cited the New York City Field Office for not receiving Baseline, Quarterly, or Follow-Up Assessments directly from the staff in the field who complete them. However, it has been made clear to OSC on a number of occasions that the NYCFO does receive crucial aspects of the assessments on a monthly basis for the purpose of effectively monitoring the City's implementation of AOT. *(Bottom of Page 9 to top of Page 10)*

* Note 6

- It is not reasonable to expect 100 percent compliance with a reporting requirement that is beyond OMH's legal mandate and is used for evaluative purposes. Since the Evaluation System was not meant to track individual cases, but rather to evaluate the overall AOT program statewide using aggregated data from numerous AOT service recipients, an 80 percent response rate is sufficient for the intended aims. Therefore, the performance in this area should be considered at least adequate. OMH also has enhanced the monitoring for timely receipt of assessments by having evaluation staff recreate the tickler file which is now distributed in the form of lists of due and overdue assessments to each agency (both case management and ACT Teams) to promote more timely submission of all assessments. *(Page 10, first full paragraph)*

* Note 7

- The Follow-Up Assessment is due at six month intervals, whether or not that coincides with expiration of the court order. *(Page 10, second sentence of second full Paragraph)*

* Note 3

* See State Comptroller's Notes, pages 41 & 42

- The frequent instances where assessments list services which differ from those in the court order are often a function of a clinically-driven change in treatment plan. Such changes are appropriate and expected. In NYC, OMH has developed a mechanism by which NYC Department of Health and Mental Hygiene notifies OMH monthly of all changes which take place in AOT orders and/or treatment plans, including, but not limited to a change in residence, thereby requiring a change in the AOT Team responsible for monitoring the case. *(Bottom of Page 10 to top of Page 11)*

Significant Events

- LIFO staff are aware of the OMH requirement to report certain serious significant events within 24 hours. *(Last sentence on Page 11)* * **Note 8**

- AOT staff in the NYCFO check weekly with their teams in an effort to ensure that they are aware of every significant event reported. Staff report to the teams on a weekly basis which Significant Event Reports have been received that week and ask to be notified of any other significant events. *(Page 12, Paragraph 2)*

Using Tact Database

- OSC misstates the review of assessments, making the broad statement that the HRFO and the LIFO "do little if any review" of the assessments. This is not accurate. *(Page 14, Paragraph 2)* * **Note 9**

Central Office Monitoring

OMH relies on the Evaluation System to understand overall trends and outcomes associated with AOT service delivery statewide. Other sources of information are used to monitor the performance of specific county AOT programs. For example, verbal reports from Field Office Program Coordinators are heavily relied upon by Central Office in determining how well county AOT programs are operating. (Bottom *of Page 15 and* top *of Page 16)*

The OSC report makes the following assertions **(see bold)** regarding the data in the Evaluation System; OMH's responses follow.

- **Data could be more accurate and reliable *(Page 17)***

  Data quality checks of the variables in the evaluation data set used to calculate outcomes show that they have high accuracy rates. Item level error rates are calculated by dividing the number of items with errors by the total number of items that were data entered. Using the same sample of forms drawn for the OSC audit the overall error rate was determined to be approximately 1 percent. This overall item level error rate matches or exceeds accepted industry standards (i.e., error rates for data used for National Center for Health Statistics * **Note 10**

surveys cite data entry rates that range from 1 to 2 percent). Table 1 displays the error rates found.

Table 1

Error Rates for Measures on Assessment Forms

Form	Total # of Errors	Total # of Data Elements	Error Rate
Baseline (44 forms)	97	10296	0.90%
Follow-Up (26 forms)	44	2106	2.09%
Total (70 forms)	141	12,402	1.10%

- **Currency of Data in Evaluation System** ***(Page 16)***

OMH's assessment of the records identified by OSC show that the statistics associated with the "amount of time to data entry" presented in the report do not characterize the typical case. We reviewed forms for which date of receipt and entry are available prior to the March 11, 2003 criterion date used by OSC. Prior to March 11, 2001, the average time to data entry was 64 days (median = 51 days). Since March 11, 2003, reflecting improvement in processes for data entry and successful efforts to reduce the backlog of forms received, the mean time to data entry for 26 forms from OSC's sample was 31 days, with a median time to data entry equal to 22 days. See Table 2.

* ***Note 11***

Table 2

Assessment of Time to Data Entry for Forms

Forms Data Entered Before March 11, 2003 N=39		Forms Data Entered After March 11, 2003 N=26	
	Days		Days
Mean	64	Mean	31
Standard Deviation	48	Standard Deviation	46
Minimum	6	Minimum	1
Maximum	206	Maximum	218
Variance	2287	Variance	2125

* See State Comptroller's Notes, page 42

- **Data entry backlog** ***(Page 16)***

  The backlog of forms received and awaiting data entry has been addressed. As of May 31, 2003, 82 percent of all forms received had been data entered, a 14 percent increase from the previous month. See Table 3 for a description of the rates of data entry in April and May 2003.

Table 3

Improved Rates of Data Entry as a Percent of Forms Received
April & May 2003

	April 2003 Cumulative Forms Received	Cumulative Forms Data Entered	Percent of Cumulative Data Entered	May 2003 Cumulative Forms Received	Cumulative Forms Data Entered	Percent of Cumulative Data Entered
Baselines	1694	1513	89%	1751	1617	92%
Quarterlies	2141	1016	47%	2250	1562	69%
Follow-Ups	1583	1170	74%	1668	1474	88%
Total	5418	3699	68%	5669	4653	82%

Attachment A

OFFICE OF MENTAL HEALTH
RESPONSE TO OFFICE OF THE STATE COMPTROLLER
DRAFT AUDIT REPORT 2002-S-2
MONITORING THE IMPLEMENTATION OF KENDRA'S LAW

I. AOT Program Implementation and Oversight

To understand the context in which OMH exercises its oversight of Assisted Outpatient Treatment (AOT), it is necessary to grasp the many levels at which monitoring of AOT clients occurs, and the key role that OMH fulfills in ensuring that local AOT programs are effectively structured and implemented.

Statewide

During the period between enactment of the Kendra's Law/AOT legislation and the effective date of November 7, 1999, OMH staff developed and disseminated guidelines necessary for implementation and operation of AOT statewide. Beginning in November 1999, counties across New York State created the mechanisms necessary to locally implement and oversee AOT.

OMH developed a staffing structure to address its obligations under MHL 9.60 for oversight and monitoring of county AOT initiatives and implementation. OMH's Commissioner appointed a Director of Assisted Outpatient Treatment to supervise statewide operation of its oversight and monitoring responsibilities of AOT on the county level.

The Director of AOT, in concert with OMH senior management, develops policy regarding AOT monitoring initiatives. In that role, the Director interfaces with numerous OMH departments and offices, including but not limited to: (1) CITER (Center for Information Technology and Evaluation Research), regarding evaluation and data collection and information systems; (2) Office of Counsel, for technical assistance on legal/procedural issues; (3) Finance, regarding the Medication Grant Program; and (4) Bureau of Forensic Services, regarding persons within the forensic mental health system. The Director of AOT also: interacts with administrators of OMH's ACT (Assertive Community Treatment) and Case Management programs, regarding services for the AOT population; holds quarterly meetings with county Directors of Community Services; and maintains contact with those personnel on an as-needed basis.

The Director of AOT has been, and continues to be, a presenter of AOT to all stakeholders including, but not limited to, providers of inpatient and outpatient services (including hospital, outpatient clinic, day program and vocational staff), recipients and the advocacy community.

Under the Director of AOT, there are five AOT Program Coordinators, each responsible to oversee and monitor counties' efforts in the geographical areas represented by OMH Field Offices, as follows: Western New York, Central New York, Hudson River, New York City, and Long Island.

OMH Field Offices

Each Field Office is staffed with an AOT Program Coordinator who is responsible for monitoring the AOT activity of the counties in the field offices geographical area. The Program Coordinators are clinically trained, Masters' level professionals who apply their clinical and administrative skills to monitoring functions. Among their duties, the OMH AOT Program Coordinators, working with local mental health directors and their AOT staff, oversee and monitor care provided to persons under AOT. They require that corrective action is taken if court-ordered services are not delivered promptly.

All AOT-related county activities are monitored. The Long Island Field Office is responsible for 2 counties, New York City has 5 counties, the Hudson River Field Office has 16 counties, the Western New York Field Office is comprised of 19 counties, and Central New York is made up of 20 counties. The Field Offices have additional staff devoted to AOT monitoring who are likewise clinically trained with extensive backgrounds in mental health.

As outlined in the law, Program Coordinators are served process on every Petition filed in court seeking an AOT Order. Court submissions are reviewed, with particular attention paid to the Physician's Affirmation, which outlines the justification or need for an AOT Order, and the proposed Treatment Plan, which indicates the Petitioner's recommendations for outpatient treatment based on psychiatric symptoms, behaviors and history. Program Coordinators and their staff rely on their clinical training in determining the appropriateness of proposed services given the information contained in the Physician's Affirmation regarding psychiatric symptoms and risk factors of the subject of each Petition filed. Immediate contact is made with county personnel to discuss questions or concerns if either the type or level of services proposed does not appear to adequately address the clinical make-up of the subject of the Petition. The proposed plan is reviewed to ensure that existing services are being utilized and that services are provided promptly.

Program Coordinators and their staff enter all relevant information into the TACT database, which is used as a reference by both Field Office and Central Office staff. This includes, but is not limited to: demographics; information regarding the subject's risk history; services ordered by the court; and any reportable incidents (e.g., non-compliance with court-ordered treatment; acts of violence; and incidence of flight, arrest, incarceration or hospitalization). Program Coordinators and their staff periodically attend court hearings, although this is not an OMH obligation under the law. However, AOT staff have at times provided valuable technical assistance and clarification to attorneys and judges involved in AOT hearings.

Program Coordinators regularly interface with County Directors of Community Services for their respective counties and receive monthly reports from such directors. Depending on the degree of activity in the particular county, they meet weekly, monthly, or quarterly. (Quarterly meetings are held in the regions with counties where few or no AOT Petitions have arisen. The majority of

counties are met with either weekly or monthly). These regularly scheduled meetings include a review of cases, technical assistance, clarification of acceptable procedures, and updates on AOT initiatives statewide. Discussions focus primarily on clinical, legal and systems issues of concern to all participants. Many of the meetings include participation of local mental health service providers (for example, case management and ACT administrators) who are themselves stakeholders in the process.

In addition to face-to-face meetings, OMH Program Coordinators and their staff have frequent phone and electronic contact with counties and other service providers as issues arise. Cases are discussed and technical assistance is provided, as needed. Systems issues are addressed immediately (e.g., service providers reluctant to serve recipients of AOT Orders, providers lacking an understanding of their role and responsibilities with regard to the legislation, issues regarding uninsured AOT recipients). All issues are followed-up through resolution. If changes in existing systems are required to effectively address such obstacles, Program Coordinators ensure appropriate and timely resolution. When necessary, other Field Office staff (e.g., Licensing and Certification, ACT, Case Management, Housing, and, at times, Directors of Field Offices) are called upon for additional support and guidance. Along these lines, counties call upon their respective Program Coordinators when they deem intervention at the State level is needed.

In addition to other functions, OMH AOT staff participate in presentations and trainings on AOT for various stakeholder groups, including, but not limited to, clinical service providers and advocates. Particular attention is paid to ongoing training of care coordination staff (Case Management and ACT).

AOT Program Coordinators periodically host AOT Forums with extensive agendas to update local county providers and county personnel on recent occurrences associated with various aspects of Kendra's Law. Topics for discussion include, but are not limited to: the current state of Kendra's Law programs; updates on ACT and residential services; presentations on Transition Management and the Medication Grant Program; a review of AOT Outcome Studies; and legal issues, with these discussions led by members of OMH Counsel and (sometimes) counsel from the State Attorney General's Offices. Such forums are met with enthusiasm and have wide participation by all stakeholders.

Program Coordinators and their staff have played a vital role in all aspects of the monitoring and oversight of Kendra's Law activities, including active participation in OMH's efforts to refine both its internal monitoring and evaluation systems.

Local Level

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

Each county has designated at least one person who has responsibility for AOT matters. Some are full-time AOT staff, while others also direct their county's Single Point of Access, case management, or ACT functions.

Directors of AOT Programs convene case conferences when there are issues of concern, whether clinical or systemic in nature. These conferences are hosted by the county's designated AOT staff and attended by all service providers, the patient under the AOT court order, and OMH staff responsible for monitoring that county's program. Such reviews are routine in nature and occur to resolve problematic issues. When more serious incidents occur, counties convene a clinical case review to learn from past practices how to improve the quality of their AOT programs. Such reviews are part of county Quality Assurance practices. They are likewise attended by all service providers on the case and by the OMH Program Coordinator and staff designated to monitor that county's AOT program.

Some counties hold weekly clinical review panels during which they review and discuss all cases referred for investigation for AOT. Typically present at these meetings are all county personnel associated with the county's AOT program, case management and ACT personnel, Comprehensive Psychiatric Emergency Program staff, and OMH AOT representatives.

While counties have developed unique AOT programs which reflect the specific needs of their communities, each has, with the assistance of OMH personnel, established a working response to its obligation under this law. Depending on specific needs, counties have focused on AOT court-ordered treatment as well as voluntary treatment regimens (known in some counties as Voluntary Agreements, in others as either Service Enhancements or Diversions) which are AOT-like, but do not have the added level of court intervention. While OMH staff do not have responsibility for monitoring the latter form of service provision, it is clear that MHL 9.60 has succeeded in garnering counties' cooperation and active participation in appropriate service provision and monitoring of subjects of AOT Orders and alternative service packages.

Distinctions Between Monitoring and Quality Assurance

OMH believes that its quality assurance and monitoring activities are inextricably linked and together help to ensure that the AOT program functions as intended. In context, all OMH's work with local governments on AOT program design and ongoing program operations creates a framework for program oversight that far exceeds the minimum requirements of the statute.

OMH's oversight of AOT is effective and is evidenced by the following:

- Every county (and NYC) in New York State has established a program under AOT to serve its residents. Each county has received valuable, on-going technical assistance, both from a Field Office and from Central Office, with regard to implementation of their AOT infrastructure, as well as guidance on the legal processes involved in obtaining AOT court orders.

- All county directors or their designees attend regular meetings chaired by the OMH Program Coordinators.

- Program Coordinators are informed about the most significant events affecting AOT recipients, and initiate appropriate follow up as necessary.

- Massive amounts of data and information are collected, entered into OMH databases, and used for program evaluation and quality improvement efforts.

- Numerous meetings have been held with various stakeholders, including counties, local providers of mental health services and mental health service recipients and their families, in an effort to educate and guide potential stakeholders in their legal obligations under MHL 9.60.

Evaluation of AOT

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

Visits to each study site allowed for direct observation of the mechanisms localities developed to implement AOT. The major components (personnel and processes) of the AOT program have been implemented in each of the nine study sites. The components are generically named to match their function. The AOT program consists of four core phases or processes - *referral, investigation, assessment and service delivery.* In the *referral* phase, an individual becomes known to the local AOT coordinator either through a direct referral from the community, or through a referral made by a local hospital or correctional facility. Upon referral, the AOT coordinator or an AOT Team (usually led by the AOT Coordinator) initiates an *investigation* to ascertain an individual's eligibility for AOT. If an individual is determined to meet the eligibility criteria, an AOT case review panel *assesses* the needs of the individual and determines whether a court-ordered treatment plan or a non-court-ordered service enhancement should be pursued. If a court-ordered treatment plan is determined to be appropriate, the court is petitioned to consider issuing a court order requiring the individual to adhere to a treatment plan. Upon issuance of the court order, the individual receives a care coordination service (case management) and other court mandated services needed to help ensure success in the community. Initial court orders may last up to 6 months and, upon expiration, can be renewed for up to one year.

As localities began to identify individuals in need of AOT, they also identified other individuals who did not require court-ordered treatment but nevertheless had unmet service needs. Many of these individuals were willing to voluntarily commit themselves to participation in necessary services. In

some areas of New York State these "service enhancements" can also include a signed service agreement, special reporting requirements for assigned case managers and increased monitoring of cases by the county. These voluntary service enhancements represent an additional unanticipated benefit from the implementation of Kendra's Law.

II. Impact of AOT on Local Mental Health Systems

Stakeholder interview data from the AOT Implementation study document the perceived impact of AOT on local service delivery from a variety of perspectives. In each locality included in the study, and across multiple stakeholder groups, there was broad recognition that the implementation of processes to provide AOT to high risk/high need recipients has resulted in beneficial structural changes to local mental health service delivery systems. New mechanisms for identifying, investigating and assessing individuals have been developed to fulfill the requirements of AOT and represent new points of accountability in local mental health service systems. Some areas of the State have established sitting AOT Teams that are staffed by influential individuals within their service systems. These are individuals who, through personal contact with providers, can ensure initial access to services or can intercede on behalf of an individual who is not receiving appropriate attention. They can move the system to meet the needs of new persons under AOT or individuals being monitored while under court order or while receiving enhanced services. Specific enhancements reported by stakeholders across counties included:

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

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

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

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

III. AOT Program Outcomes

Another key element to consider in judging the adequacy of OMH's oversight of AOT is the success that the program has had in helping recipients to live more safely and successfully in the community. Although not specifically required by the AOT statute, OMH collects detailed information on individual AOT recipients, and has used this data to conduct statistical analyses of the impact of AOT on the population served by the program Statewide.

AOT Evaluation Database

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

- general demographic characteristics of individuals; status of individuals in such areas as living situation, education and employment; services received; engagement in services; and adherence with prescribed medication;
- data on the incidence of significant events such as hospitalization, homelessness, arrest and incarceration; and
- functional assessments in the areas of: self-care; social skills and task performance; and the incidence of behaviors harmful to the individual or others.

When compared with a similar population of mental health service recipients, persons under AOT were twice as likely to have had prior contact with the criminal justice system and 50% more likely to have had a previous episode of homelessness. In addition, individuals who have received an AOT court order were 50% more likely to have a co-occurring substance abuse problem.

Outcomes for AOT Recipients

AOT was designed to ensure supervision of routine care and treatment for individuals who would be unable to take responsibility for their own care and live successfully in the community without such supervision. For persons under AOT, the goals include increasing access to the highest intensity services, better engagement in services, and reduction of incidences of behaviors harmful to themselves or others. Participation in AOT should result in improved adherence with prescribed medication and decreased hospitalization, homelessness, arrests and incarceration. In addition, individuals under AOT should benefit from services through improved functioning in important community and personal activities.

For all categories of service, a greater percentage of individuals are participating in the service while under court order than were receiving it prior to the court order. The most dramatic example is in the area of case management. As prescribed by the legislation, all individuals receiving a court order are enrolled in case management. However, prior to AOT, only 52% of these individuals were receiving this service.

In addition, the percentage of AOT individuals who are receiving substance abuse services doubled (from 26% to 52%) as a result of their court-ordered treatment plans. Similarly, the percentage of persons under AOT who receive housing services as a result of their court-ordered treatment plans increased from 23% to 41%. Substantial increases are also seen for urine or blood testing, which is used to determine adherence to medication or to detect substance abuse.

After six months of participation in AOT, the incidence of homelessness, hospitalization, arrest and incarceration had all declined significantly from pre-AOT levels.

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

To assess medication adherence, case managers were asked to rate adherence of persons under AOT using a scale ranging from "taking medication exactly as prescribed" to "rarely or never taking medication as prescribed." The resulting data show that the percent of individuals with poor medication adherence dropped significantly (from 67% to 22%) after six months, a significant improvement in engagement in services and medication adherence after six months of AOT participation.

In summary, individuals under AOT court orders showed improved functioning in the areas of self care, community living, interpersonal functioning and task performance during the first six months of court-ordered treatment. Incidence of psychiatric hospitalization, homelessness, arrests and

incarceration decreased from pre-AOT levels. Statistically significant reductions also occurred in harmful behaviors such as substance abuse, suicide attempts, and physical harm to self.

OMH continues to monitor the characteristics and outcomes of persons who are under court order. Evaluation results are reviewed monthly in a quality improvement process to identify opportunities for program improvement and policy change. In addition to OMH's ongoing AOT program evaluation and monitoring activities, OMH researchers, in collaboration with researchers at the Columbia University Mailman School of Public Health, have launched a controlled study to establish AOT's effectiveness in the reduction of harmful behaviors, incarceration and psychiatric hospitalization.

State Comptroller's Notes

1. We clarified our recommendation to state that OMH should improve field office oversight and monitoring activities by documenting any contacts made regarding AOT clients. Doing so would enable the OMH program coordinators to clearly show the steps they have taken to oversee and monitor the counties' AOT programs, which is an area that we found to be lacking during the audit.

2. As we disclose in our report, to be able to effectively monitor the AOT program, field offices must have access to client progress data to help ensure that AOT clients are receiving the services identified in the court order. However, we identified errors and discrepancies in 61 of the 65 cases reviewed, and we also identified numerous instances where TACT data was incomplete. We maintain that to meet its oversight responsibilities, OMH needs accurate and current information about AOT clients.

3. We modified our report accordingly.

4. Our findings support the conclusions reached regarding OMH's field office monitoring activities. OMH program coordinators are responsible for overseeing the local mental health organizations' administration of the AOT program. We identified a number of deficiencies in the program coordinators oversight activities. For example, we found that the program coordinators do not adequately document their contacts with local AOT programs, and have not taken the steps necessary to ensure that significant events are reported properly, consistently and within stipulated timeframes. Hence, we recommend that OMH take the steps necessary to improve its field office oversight and monitoring activities.

5. According to OMH's program coordinators in the three field offices we visited, they maintain contact with local AOT programs by means of e-mail and telephone, weekly and/or quarterly meetings, and periodic visits to local AOT program offices. However, the program coordinators were generally unable to document these contacts. For example, minutes of the meetings were not kept and the agendas were not detailed. Without documentation of field office monitoring of local AOT programs, there is reduced assurance that such monitoring is taking place and is adequate.

6. As stated in our report, New York City officials had not directly received case management reports since September 2001. Instead, these reports were sent directly to OMH Central Office. According to New York City field office officials, they reviewed only the significant event sections of the Quarterly and Follow-up reports for those reports that Central Office forwarded to them.

7. Monitoring the implementation of Kendra's Law is a responsibility that OMH shares with local governments. Since OMH's program coordinators are responsible for ensuring that AOT clients receive treatment in a timely manner, review of case manager reports would help program coordinators fulfill their monitoring function. Hence, we do not agree with OMH's contention that an 80 percent response rate is sufficient and as such we recommend that OMH implement procedures to determine that all required reports are provided. We note that OMH officials have enhanced their monitoring of the timely receipt of assessments.

8. As stated in our report, Long Island officials stated they were unaware of the OMH requirement to report certain serious significant events within 24 hours.

9. As stated in our report, Hudson River and Long Island officials stated they do little if any review of the Quarterly reports before they forward them to Central Office.

10. We do not agree with OMH's assertion regarding high data accuracy rates. As documented in our report, we determined that Evaluation System data did not match hard-copy reports for 50 of the 68 reports (74 percent) we reviewed. We concentrated our review on the critical data elements relating to AOT client treatment. As such, we maintain that OMH needs to take action to improve the accuracy of this information to enable a proper assessment of program outcomes.

11. We commend OMH for taking action to reduce the backlog of reports awaiting data entry into the Evaluation System. However, we do not agree that our findings do not characterize the typical case. We found that on average, it took approximately five months from the date Central Office received a report until personnel entered the information into the Evaluation System. Further, since reports are often received late, the average time for entry into the Evaluation System increases to 317 days when you compare to the actual due date of the report. We attributed the backlog to the lack of timeframe requirements for entering report data and an absence of a policy about how to prioritize data entry tasks to reduce the backlog. Hence, we recommend that OMH take action to address these matters.