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Inside

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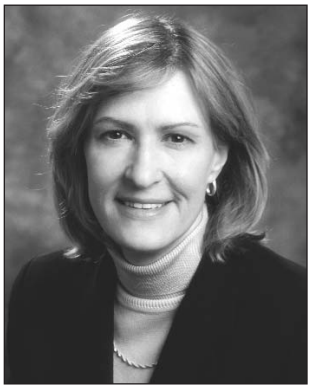
A Message from the Chair



I have been thinking a lot about New Orleans since the Annual Meeting, especially about how failures to both plan and act exponentially compounded the impact of the crisis. Reviews from our Annual Meeting on health care provider disaster preparedness were generally enthusiastic. Among the few dissenters was a participant who was critical of the program because it addressed an area in which he or she had little involvement. And in fact, except for our esteemed speakers, probably few of us present actually have significant involvement in advising our health care clients on disaster preparedness. Other than stocking up on batteries or duct tape, or fretting about the latest article on bird flu, we all have our share of "real" work to do that commands our daily attention. Those contracts and court papers piling up on our desks inevitably take precedent over a theoretical set of problems looming somewhere, sometime in the future.

But as professionals we will have much to do if that somewhere, sometime disaster does befall us. As demonstrated by the New Orleans debacle, how laws and policies are interpreted during a crisis matters tremendously. Our clients will look to us as their lawyers to make those calls. So, for me, the very fact that most of us are not conversant in these areas was a compelling reason to host this meeting. At least for one very full day, everyone who attended focused on disaster preparedness. And we brought together a number of speakers who will be on the front lines in any disaster and provided the opportunity for them to interact and share ideas among themselves as well as with the group.

In our panel entitled "Lessons From New Orleans," we were fortunate to host speakers Joseph Donchess, the Executive Director of the Louisiana Nursing Home Association; John Mattesino, President of the Louisiana Hospital Association; and James Cobb, an attorney representing nursing home operators being prosecuted for flooding-related deaths. When presented with the idea of this panel by Margie Davino, the program chair, I envisioned a scholarly discussion in which the panel would provide us with power points of key legal issues they had encountered during the disaster, along with some Monday morning quarterbacking-type advice. What I did not anticipate was the emotional punch of the presentations by our Southern brethren. Here we were talking about HIPAA, credentialing out-of-state pharmacists, and jurisdictional issues. Then our New Orleans speakers brought us back to grim reality, with slides of hospitals under water, patients being evacuated in boats and bodies floating in the dirty sewage. How bloodless all the legal theory suddenly seemed when juxtaposed against those images.

We are fortunate in New York to have the time to debate theory now before we are compelled to make quick decisions and take action. In a disaster, unresolved issues will cost lives. I am grateful to our friends from Louisiana for sharing their experiences with us—they all are heroes and still need our help to rebuild their vibrant community.

"Think how the New Orleans disaster response would have been far more effective if government officials had focused on meeting community needs instead of on parsing jurisdictional conflicts of laws."

I have learned my own lessons from information provided during our Annual Meeting. Here are a few I will pass along to my health care clients:

1. Find some way to document every patient encounter in an emergency or you will not be paid. Many hospitals in New Orleans have yet to be reimbursed for their work during the hurricane because of a lack of documentation.

2. Susan Waltman, SVP and General Counsel, GNYHA, advises that when making the tough calls in a crisis situation, draw upon your experience and legal knowledge, but use a "reasonableness" standard as your primary guide. (Susan ably navigated the NYC hospital response to 9/11). Think how the New Orleans disaster response would have been far more effective if government officials had focused on meeting community needs instead of on parsing jurisdictional conflicts of laws.

3. Don't despair if you "over plan" for a crisis that never occurs. According to Ms. Waltman, in 1999 health care providers and officials devoted considerable efforts to planning, and building col-

laborative networks, in anticipation of a Y2K disaster which never occurred. But less than two years later, that planning enabled NY's health care system to respond effectively to the 9/11 attacks, which obviously were unanticipated.

4. Association leadership is key to coordinating health care provider response. Both Louisiana and New York association leaders manned control centers day and night throughout the hurricanes and 9/11, respectively. In Louisiana, it appeared that the hospital and nursing home response was the one area of crisis management in which there was a rational plan, largely because of these dedicated individuals. Support the efforts of associations to plan for and partner with government in disaster preparedness initiatives.

5. Do some "at home" disaster preparedness, so you can survive long enough to lend assistance in a crisis. During his kick-off presentation on potential disasters facing our region, Dr. Irwin Redliner, Director of the National Center for Disaster Preparedness at Columbia University, asked who in the 150-person audience felt they were prepared for a disaster. Only one person raised her hand.

This Special Edition of the *Health Law Journal* is devoted to Mental Health Issues. My thanks go to Henry Dlugacz, Special Editor, to the contributors, and to *Journal* Editor Robert Swidler for this excellent publication. Thanks also to the members of the Health Law Section for your support this year during my tenure as Chair. It is a pleasure working with all of you.

Lynn Stansel

Cover artwork:
***The Copse* by Paul Cezanne (1888)**

In the New York State Courts

By Leonard M. Rosenberg

Home Health Care Provider Is Entitled to Notice and Opportunity to Be Heard Prior to the State Acting to Recover Alleged Medicaid Overpayments

Visiting Nurse Service of New York Home Care v. New York State Department of Health, 5 N.Y.3d 499, 806 N.Y.S.2d 465 (November 17, 2005). In this case, the Court of Appeals held that a home health care provider is entitled to notice and an opportunity to be heard on the issue of whether it took reasonable measures to ensure proper designation and processing of Medicaid reimbursement claims before the Department of Health (DOH) acted to recover alleged overpayments.

Petitioner Visiting Nurse Service of New York Home Care (VNS), a not-for-profit certified home health agency, is a participating provider in New York's Medicaid program, which is administered by DOH. This action arose from DOH's effort to recoup amounts paid by Medicaid that should have been billed to Medicare. (The payments were for services rendered to "dual-eligible" patients, i.e., patients covered by Medicare and Medicaid. Since by law Medicaid is the payor of last resort, services to dual-eligible patients must be billed to Medicare first.)

DOH determined that VNS's liability was $38.2 million. VNS then billed Medicare, which paid all but $10 million of the claims, which were denied as untimely submitted. VNS repaid to DOH the Medicaid payments subsequently covered by Medicare, but challenged DOH's right to recoup the rest, especially without notice and a hearing. VNS commenced an Article 78 proceeding that challenged the State's withholding of Medicaid funds, asserting that it was not obligated to repay Medicaid unless it had actually received

payment for the services provided from Medicare or some other source.

The Supreme Court granted VNS's petition, concluding that VNS had a property interest in the Medicaid payments that was protected by due process. Thus, DOH was required to conduct a hearing before recovering the funds. The Appellate Division for the Third Department affirmed, ruling that VNS was entitled to a hearing to determine if reasonable measures had been undertaken to assess whether the disputed claims were eligible for payment by Medicare or other third-party payors before submission to Medicaid. The Court of Appeals likewise held that a hearing must be held on the issue of whether VNS took reasonable measures to ensure the proper designation and processing of claims.

DOH argued that notice and an opportunity to be heard need not be provided to VNS before recoupment efforts are undertaken because the regulations state that Medicaid payments to home health care providers are conditional pending post-payment audit review. The Court disagreed, explaining that 18 N.Y.C.R.R. § 518.5, the regulations that cover home health care providers, state that if DOH determines that any person has submitted or caused to be submitted claims for medical care, it may require repayment of the amount determined to have been overpaid, but only after a notice of the overpayment and an opportunity to be heard.

The Court noted that determination of whether VNS satisfied the requirement that reasonable measures be taken to ensure the correct processing of claims requires an examination of the provider's initial assessment that a claim was not eligible for Medicare or other third-party reimbursement, and its actions after being notified that a Medicaid-reimbursed claim should be resubmitted to a different payor. At the hearing, the burden will be on VNS to prove that it acted reasonably when it decided to submit the claims at issue to Medicaid rather than to Medicare or other payors, and when it was subsequently notified by the auditor that certain claims should be resubmitted for Medicare reimbursement eligibility.

The Court also addressed whether DOH was properly ordered to cease recoupment pending the administrative hearing. The Court held that DOH regulations permit recoupment efforts to commence prior to a hearing. However, because DOH was unable to proceed within 90 days of VNS's request for a hearing, the Court held that pursuant to DOH regulations, any recovery should be stayed pending the commencement of the hearing and any delays occasioned by or attributable to the department will forestall the commencement or continuation of recoupment.

State Supreme Court Rejects State Psychiatric Hospital's Attempt to Use Mental Health Law to Civilly Confine Violent Prisoners After Their Prison Terms Ended

State (Harkavy) v. Consilvio, 10 Misc. 3d 851 (2005) (S. Ct., N.Y. County 2005) (*"Harkavy I"*). Mental Hygiene Legal Service (MHLS) Director Harkavy petitioned the State Supreme Court for a writ of habeas corpus, seeking the release of 12 ex-prisoners who were transferred from prison to a psychiatric hospital at the conclusion of their terms of imprisonment as a means of avoid-

ing their release. The civil confinement was accomplished pursuant to Mental Hygiene Law section 9.27(a), which provides for the involuntary hospitalization of persons who are mentally ill, in need of involuntary care and treatment, and who pose a danger to themselves or society. Petitioners contended that the State failed to follow the proper procedures in transferring inmates to a mental hospital, which is governed by section 402 of the Correction Law, and that they were denied their constitutional right to due process before being transferred from prison into a mental health institution.

The Court noted that since 1999, at least five bills had been introduced in the New York Legislature proposing involuntary civil confinement of sex offenders, and that in October 2005 it was widely reported in the press that Governor Pataki could not wait any longer for the Assembly leadership to act on his proposal. Charging state officials to "push the envelope" with the application of existing state law, the Governor ordered state correction and mental hygiene authorities to begin evaluating every sexually violent predator in state prisons before their release to determine if they should be civilly confined.

The Court found that the petitioners were deprived of the due process protections afforded to prisoners under the provisions of Correction Law § 402, and were being illegally detained. It directed the State to release the petitioners unless it secures an expeditious examination of each of the petitioners by two independent examining physicians to be appointed by the court. Both physicians must certify that each of the petitioners are mentally ill, in need of care and treatment at a psychiatric hospital, and pose a substantial threat of physical harm to themselves or others.

State (Harkavy) v. Consilvio, 2006 N.Y. Slip Op. 50191 (S. Ct., N.Y. County 2006)(*"Harkavy II"*). In *Harkavy II,* MHLS again sought the immediate release of former inmates (hereinafter "Petitioners") who were transferred from various prisons to the Kirby Forensic Psychiatric Center (hereinafter "Kirby") after completing prison terms for sexually violent offenses. In this case, the Respondents asserted that the procedure set forth in Correction Law § 402 were inapplicable, because the Petitioners were not committed to Kirby until after their prison terms had expired. As such, Respondent contended the Petitioners were entitled to no greater protection than that afforded to any other free citizen under Article 9 of the Mental Hygiene Law. However, the Court agreed with Petitioner's argument that the they were entitled to the enhanced due process protections set forth in Correction Law § 402, because in reality, they were in the custody of the Department of Corrections from the time their sentences expired until the time they were admitted to Kirby.

In re Estate of Wolseley

In re Estate of Wolseley, 10 Misc. 3d 1077(A), 2005 Slip Op. 52251; 2005 WL 3726198 (N.Y. Sur. Ct., Suffolk County 2005). Central Suffolk Hospital Association (the "Hospital") petitioned the Suffolk County Surrogate's Court for an order pursuant to the *cy pres* doctrine, codified in Estates Powers and Trusts Law (EPTL) § 8-1.1, removing a bequest restriction which limited the use of bequeathed funds totaling approximately $14 million for the Hospital's ophthalmology department. The Court granted the Hospital's petition and gave the Hospital permission to use the funds to pay down its debt and finance an expansion and modernization project.

The Hospital was the beneficiary of a gift (the "Bequest") from the Last Will and Testament of Charles William Wolseley, dated October 17, 1978 (the "Will"). The value of the Bequest at the time it was made was approximately $1.4 million, but by 2005 had increased in value nearly ten-fold, to approximately $14 million. The Bequest, however, stated that the funds should be used for the Hospital's Ophthalmology Service. There was no gift-over provision in the event the disposition failed. Due to the restrictive language, the Hospital sought application of the *cy pres* doctrine to accomplish the general charitable purposes of the testator, by granting permission to use the bequeathed funds to implement its revitalization plan.

The Hospital is a voluntary, not-for-profit hospital corporation organized and existing for the purpose of delivering health care services to the surrounding community. Although the Hospital does provide ophthalmology services, in 2004 there were only seven patients admitted to the hospital for eye-related disorders and less than five hundred emergency or outpatient eye-related visits. In its Petition, the Hospital explained that it was experiencing fiscal difficulties that threatened its viability due to several factors, including decreasing reimbursement for services and/or capital improvements, its limited capacity to serve a growing community and the aging of its facilities.

The Hospital argued that its financial condition, dramatic changes in the health care industry which the testator could not have foreseen, and the significant growth in the value of the Bequest, made it impossible or impracticable for the Hospital to apply nearly $14 million to its "Ophthalmology Service." However, the Hospital asserted that access to nearly $14 million would be sufficient for it to achieve economic stability and thus obtain the financing required to proceed with its much-needed modernization and expansion projects. Accordingly, the Hospital petitioned the Court to lift the restriction and make the funds available to pay down its debt and finance the expansion and modernization projects. In connection with the relief sought, the Hospital obtained the approval of the New

York State Attorney General's Charities Bureau.

Before a court may properly apply the *cy pres* doctrine, it must find three conditions: (1) the gift or trust must be charitable in nature; (2) the language of the will or trust instrument, when read in the light of all attendant circumstances, must indicate that the donor demonstrated a general, rather than specific, charitable intent; and (3) it must be determined to the court's satisfaction that the particular purpose for which the gift or trust was created has failed, or has become impossible or impracticable to achieve.

As detailed in its opinion, the Suffolk County Surrogate's Court found that all three conditions had been met. In so holding, the Court found it significant that without the unrestricted use of the funds, the Hospital's continued existence would be in jeopardy, frustrating the testator's charitable intent and eliminating a valuable community service. [*Editor's Note*: Leonard M. Rosenberg and Lauren Levine of Garfunkel, Wild & Travis represented the Hospital in this matter.]

In Patient's Civil Suit for Battery, Physician Is Collaterally Estopped from Re-litigating Issues Decided at OPMC Hearing

Richards v. Smith, 9 Misc. 3d 670, 802 N.Y.S.2d 850 (Sup. Ct., Kings County 2005). In *Richards*, plaintiff alleged that during a physical examination, defendant physician inappropriately touched her and committed a battery. The issue that the Court addressed was whether the patient could invoke the collateral estoppel doctrine to preclude the defendant from re-litigating the finding of the State Office of Professional Medical Conduct (OPMC) that the physician committed a battery on the patient.

The collateral estoppel doctrine precludes a party from re-litigating in a subsequent action or proceeding, an issue raised in a prior action or proceeding and decided against that party or those in privy. To invoke collateral estoppel, it is required that (1) an issue in the present proceeding be identical to that necessarily decided in the prior proceeding, and (2) in the prior proceeding the party against whom preclusion is sought was afforded a full and fair opportunity to contest the issue.

The Court held that the plaintiff had satisfied her burden that the battery issue in the civil action was the same as that raised in the OPMC hearing, and that the issue was conclusively decided in the findings by the OPMC's hearing committee. In addition, the court found that the defendant had a full and fair opportunity to contest the battery issue at the OPMC's disciplinary hearing because he was represented by counsel and had an opportunity to testify and call witnesses on his behalf.

Defendant argued that collateral estoppel did not apply under *Jeffries v. Griffin*, 1 N.Y.3d 34, 801 N.E.2d 404, 769 N.Y.S.2d 184 (2005). In *Jeffries*, the defendant physician was criminally convicted of first degree sodomy for allegedly sodomizing a female patient as she underwent an office procedure under heavy sedation. Subsequent to the criminal conviction, the Department of Health revoked the physician's license. Thereafter, the physician's criminal conviction was reversed and on retrial he was acquitted of all the criminal charges. The Court in *Jeffrie*s held that because defendant was later acquitted, he should not be precluded from contesting liability for assault and battery in plaintiff's civil action. In *Richards*, the Court distinguished *Jeffries* because here the decision of the OPMC committee was not based on defendant's criminal conviction (in fact, defendant was acquitted in a criminal case prior to the OPMC hearing), but on testimony and evidence presented at the OPMC hearing.

Disclosing Confidential HIV Information to Correction Officer Guarding a Patient, Without Notifying Officer that Further Disclosure of Information Is Prohibited, Violates Article 27-F of the Public Health Law

Melendez v. Strong Memorial Hospital, 804 N.Y.S.2d 626 (Sup. Ct., Kings County 2005). Plaintiff, an inmate at the Willard Drug Treatment Campus, alleged that a Strong Memorial Hospital employee's disclosure of his HIV positive status to the corrections officer accompanying the inmate, and the officer's redisclosure of that information to staff of the Treatment Campus, violated Public Health Law (PHL) Article 27-F (PHL § 2782), and caused him to suffer mentally, physically, and emotionally.

Plaintiff inmate was brought by a corrections officer to the hospital for an office visit at the infectious disease clinic. Prior to discussing the plaintiff's HIV status, the nurse requested that the officer exit the examination room, but the officer refused. The nurse then discussed the plaintiff's medical condition, and disclosed his HIV positive status to the corrections officer. The officer subsequently disclosed the confidential health information to other members of the Willard Drug Treatment Campus staff. The inmate sued, and the Hospital sought summary judgment dismissal of the suit.

Under 9 N.Y.C.R.R. § 7064.8(a)(15), a person who obtains confidential HIV-related information in the course of providing health or social service may not disclose or be compelled to disclose such information, except to an employee or agent of a provider of health or social services when necessary to provide supervision, monitoring or administration of services, and when an employee has access in the ordinary course of business to records related to the care, treatment, or provision of a health or social service. Disclosure to an employee is allowed only

when necessary to (a) enable the chief administrative officer to appropriately maintain custody and supervision of the protected person and (b) the medical director reasonably believes that without disclosure circumstances will exist creating a significant risk. In addition, PHL § 2782 provides that disclosure may not be made unless to an employee of the Commission of Correction to the extent the employee is authorized to access records containing such information to carry out the Commission's function, powers, and duties.

The court held that the corrections officer was neither an employee of the commission nor its authorized agent and thus, PHL § 2782 required such disclosure to be accompanied or followed by a statement in writing, within ten days, that includes the following statement: "This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for release of medical or other information is NOT sufficient for further disclosure."

The court also held that it was foreseeable that the HIV status of the plaintiff would continue to be disseminated once released in the presence of a third party, and denied the Hospital's motion for summary judgment.

Daughter As Health Care Agent of Her Mother Is Entitled to Copies of Mother's Medical Records for the Purpose of Facilitating Appropriate Treatment by the Patient's Subsequent Caregivers

Mougiannis v. North Shore-Long Island Jewish Health System, Inc., 2005 WL 3117344 (2d Dep't 2005). In *Mougiannis*, petitioner commenced an Article 78 proceeding to compel the Hospital to provide her with complete copies of her mother's medical records, so that she could provide them to her mother's new caregivers. The daughter was appointed as the health care agent of her mother by a health care proxy executed on July 11, 1997, pursuant to PHL Article 29-C. During the mother's hospitalization, the Hospital provided the daughter with access to her mother's medical records. Once the mother was discharged, however, the Hospital denied such requests on the grounds that the daughter was not a "qualified person" entitled to access under PHL § 18, and this proceeding ensued.

The Supreme Court determined that the daughter was a "qualified person" as defined in PHL § 18(1)(g), and entitled to have her request processed in accordance with the procedures set out in PHL § 18. In addition, the Court held that any right to have such access as health care agent under PHL § 2982(3) terminated upon her mother's discharge from the Hospital. The Appellate Division first held that the petitioner is not a "qualified person" as defined in PHL § 18(1)(g). However, the Court ruled that under PHL § 2982(3), the petitioner does have the right to the requested medical records to the extent necessary to make informed decisions regarding her mother's ongoing health care.

Section 18 of the PHL creates a right in favor of a limited class of "qualified persons" to inspect and obtain copies of records containing patient information, and sets forth detailed procedures governing the manner by which that right may be exercised. The Appellate Division analyzed the definitions of "qualified persons" in PHL § 18 and held that health care agents appointed pursuant to PHL Article 29-C are not included, concluding that it was the intent of the legislature not to include health care agents among those "qualified persons" entitled to obtain copies of their principals medical records pursuant to PHL § 18.

Instead, the Court used another provision of the PHL to grant the daughter relief. PHL § 2982 states that subject to any express limitations in the health care proxy, an agent shall have the authority to make any and all health care decisions on the principal's behalf that the principal could make. In addition, notwithstanding *any law to the contrary*, the agent shall have the right to receive medical information and medical and clinical records necessary to make informed decisions regarding the principal's health care. The definition of "health care" includes "*any* treatment, service or procedure to diagnose or treat an individual's physical or mental condition."

In addition, the Court explained that the clear purpose of PHL § 2982(3) is to enable the agent generally to make "informed decisions" regarding the principal's health care. In addition, a health care agent's right to obtain medical information under PHL § 2982(3) is neither limited in scope to the records of the health care facility in which the principal is currently admitted for treatment, nor limited in time to the period during which the principal is receiving treatment at that facility. The Court noted that this is true irrespective of whether such information and records pertain to current or past hospitalizations or treatments, and whether the health care provider to whom the request is directed is still treating the principal. In addition, the Court pointed out that any conflict between the scope of PHL § 2982(3) and the rights granted to "qualified persons" under PHL § 18 must be resolved in favor of disclosure pursuant to PHL § 2982(3), which operates "notwithstanding any law to the contrary." Thus, the Court directed the Hospital to reconsider petitioner's request.

Hospital Was Not Liable for Private Physician's Malpractice and Failure to Obtain Informed Consent for a Pedicle Screw System

Sita v. Long Island Jewish—Hillside Medical Center, 804 N.Y.S.2d 112 (2d Dep't 2005). In *Sita*, a patient whose back condition was treated with a pedicle screw system brought a medical malpractice action against Long Island Jewish Hillside Medical Center. The Hospital appealed from the denial of its motion for summary judgment.

The Court held that summary judgment should have been granted, because plaintiff was treated by his private physician, who was not an employee of the Hospital. Thus, the Hospital could not be held vicariously liable for his alleged malpractice. Similarly, it was the duty of the injured plaintiff's private physician and not the Hospital to obtain the plaintiff's informed consent to use the pedicle screw system. Here, there was no indication that the Hospital knew or should have known that the injured plaintiff's physician was acting without informed consent, or that the Hospital had reason to suspect malpractice. The Court also held that on the issue of negligent hiring and supervision, plaintiff failed to identify any negligently hired or supervised employee of the Hospital.

Regarding the FDA's approval of the pedicle screw system used to treat the injured plaintiff's back condition, the Court analyzed 21 U.S.C. § 396, and held that although marketing and promotion of the pedicle screw system was not approved by the Food and Drug Administration, that did not prevent the physician from using the system in an "off-label manner." Further, the pedicle system used was considered the standard of care in the community. In addition, because the injured plaintiff was not participating in a clinical investigation, FDA regulations did not require the Hospital to obtain his informed consent or to disclose the regulatory status of the pedicle screw system.

Hospital Met Burden for Summary Judgment on a Claim of Negligent Hiring and Supervision Because It Acted with Reasonable Care in Hiring and Retaining Nurse

Travis v. United Health Services Hospitals, Inc., 23 A.D.3d 884, 804 N.Y.S.2d 840, (3d Dep't 2005). Plaintiff, a patient at United Health Services Hospitals, alleged that a male nurse sexually assaulted her while she was in a sedated state after a surgical procedure. Plaintiff sued the Hospital, alleging negligent hiring, supervision, and retention. The Hospital moved for summary judgment.

On appeal, the Court affirmed summary judgment for the Hospital. The Court held that a claim based on negligent hiring and supervision requires a showing that the Hospital knew of the employee's propensity to commit the alleged acts, or that the defendant should have known of such propensity had it conducted an adequate hiring investigation. The Hospital met its burden of establishing that it acted with reasonable care in hiring and retaining the subject nurse. The Hospital submitted evidence that it had screening procedures in place and employed those procedures when hiring the subject nurse, by submitting evidence that these procedures were in accord with acceptable Hospital practice and no irregularities or negative information about this nurse was revealed during the Hospital's review of the defendant's background and credentials.

With respect to the claim that the Hospital was negligent in supervising and retaining the nurse, the court found that the plaintiff failed to raise a question of fact. There was no evidence indicating that the nurse engaged in any inappropriate sexual behavior with a patient while employed by the Hospital. Although there was a prior allegation of inappropriate sexual contact between the nurse and a co-worker, the Court held that such an allegation, even if true, would not make it reasonably foreseeable that the nurse would sexually assault a sedated patient.

HMO Deemed Justified in Terminating Physician Who Was Subject to Final Disciplinary Action Restricting His Ability to Practice Medicine

Abramo v. Healthnow New York, Inc., 23 A.D.3d 986, 803 N.Y.S.2d 842 (4th Dep't 2005). Plaintiff physician was the subject of a final disciplinary action by the New York State Board for Professional Medical Conduct "resulting in a consent order that contained conditions impairing plaintiff's ability to practice medicine." Accordingly, defendant HMO terminated plaintiff as a participating physician. The physician sued the HMO for breach of contract, and the HMO responded with a motion for summary judgment. The motion court denied the HMO's motion.

The Appellate Division reversed, stating that, "[i]t is well settled that the interpretation of the terms of an unambiguous written agreement is a function for the court." Accordingly, the Court held that, based upon the "only practical interpretation" of the agreement between plaintiff and defendant HMO justified the termination of plaintiff as a participating physician in the HMO, and defendant was entitled to judgment as a matter of law.

Court Holds that Hospital's Credentials Files on Physician Are Privileged and Exempt from Discovery

Powers v. Faxton Hospital, 23 A.D.3d 1105, 803 N.Y.S.2d 871 (4th Dep't 2005). The Appellate Division affirmed a lower court ruling denying plaintiff's access to defendant hospital's credentialing and privileging files regarding a physician, because those documents were obtained and maintained as part of its medical quality assessment and review process. Accordingly, the

information is confidential and exempt from disclosure in discovery pursuant to Education Law § 6527(3) and Public Health Law § 2805-m(2). The Court also held that the lower court was correct in not permitting an *in camera* review of the files because there was no evidence that any part of the information sought is outside the protection of the Education and Public Health Laws.

Termination of Anesthesiologist Did Not Violate Age Discrimination in Employment Act

Ospina v. Susquehanna Anesthesia Affiliates, 23 A.D.3d 797, 803 N.Y.S.2d 751 (3d Dep't 2005). The Appellate Division affirmed a lower court's decision finding that the termination of an anesthesiologist by his employer was not a violation of the Age Discrimination in Employment Act (ADEA). The 65-year-old physician had previously requested a leave of absence because the work became "excessive" and he "felt tired." After the leave of absence, plaintiff asked to return on a part-time basis, handling only low-risk cases, a request that the employer found impossible to meet. Moreover, numerous surgeons complained about plaintiff's performance during surgery or outright refused to work with him based on a belief that he was a danger to patients.

The Court found that this constituted a legitimate, non-discriminatory reason for plaintiff's termination. The Court also affirmed that the hiring of younger physicians prior to plaintiff's discharge did not demonstrate pretext, and that plaintiff's denial that he caused any patient injury was irrelevant, as a challenge to the correctness of the employer's termination decision, without more, is insufficient to raise an inference of discrimination.

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a partner in the firm of Garfunkel, Wild & Travis, P.C., a full service health care firm representing hospitals, health care systems, physician group practices, individual practitioners, nursing homes and other health-related businesses and organizations. Mr. Rosenberg is Chair of the firm's litigation group, and his practice includes advising clients concerning general health care law issues and litigation, including medical staff and peer review issues, employment law, disability discrimination, defamation, contract, administrative and regulatory issues, professional discipline, and directors' and officers' liability claims.

In the New York State Legislature

By James W. Lytle

Mental Health Legislation, 2006 Legislative Session

The focus of this issue of the *Health Law Journal* warranted devoting this column space to mental health issues before the New York State Legislature. The mental health field has been an important part of the health and human services landscape for decades, particularly as the distinctions between physical health and mental health issues have slowly diminished and the stigma surrounding mental health has begun to fade. While the State's role as the direct provider of mental health care substantially—and appropriately—declined over the last several decades of the 20th Century, mental health providers and advocates continue to look to Albany in an attempt to create a better mental health service delivery system for the 21st Century.

Among the issues likely to be debated during 2006 are the following:

Mental Health Parity: For a decade or more, mental health advocates have sought legislative change at both the state and federal level to curb the widespread practice by health insurers and HMOs of providing strict limitations on the extent to which inpatient and outpatient mental health services will be covered by third-party plans. Even though health plans are unlikely to single out other diseases, disabilities or conditions for limits on coverage, limitations on mental health benefits are virtually universal and higher copays and deductibles are often charged for the receipt of mental health care. A federal statute was enacted a number of years ago, but it has not proven to have had a very significant impact on insurance practices and, as a result, many states have enacted stronger state laws to address this issue.

A comprehensive proposal, Assembly 2912 (Tonko) has been named "Timothy's Law" in memory of a twelve-year-old boy who committed suicide after suffering from mental illness that his parents' coverage did not adequately address. The bill would preclude the imposition of arbitrary limits on mental health visits or inpatient stays and require that deductibles and coinsurance be applied in a non-discriminatory fashion. While the bill has a Senate companion (Senate 6735), its sponsor, Senator Duane, is a member of the Senate Democratic minority and the bill is not likely to be favorably considered. Opposition from the small and large business communities has been fierce, even though the bill's advocates contend that the actuarial evidence would suggest that the bill would have only a modest impact on premiums. An alternative proposal, Senate 1672 (Libous), obtained Senate passage in the past and efforts are continuing to see if a middle ground might be reached to address this issue in a manner that can secure passage by both Houses of the Legislature.

Adult Home Residents: The discharge of psychiatric patients from State psychiatric hospitals resulted in the admission of many patients with mental illness in adult homes—many of which were neither designed nor equipped to address the needs of persons with psychiatric disabilities and often did not provide people with an opportunity to recover and participate in community life.

Thanks to a *New York Times* exposé, a number of steps have been taken to address these issues, but legislation remains pending to enhance adult home services and protect the rights of their residents. Assembly 6724 (Gottfried) would provide for a stronger regulatory structure relating to the operation of an adult home: its administrators, like nursing home administrators, would be licensed; its establishment, like Article 28 health care facilities, would be subject to Public Health Council review; enforcement provisions and penalties would mirror those that face health care institutions and the Commissioner would have the capacity to appoint a temporary operator if that appeared to be necessary.

Another proposal, Senate 4878-A (Morahan)/Assembly 2917-A (Rivera) would permit adult home residents the opportunity to seek the appointment of a receiver when conditions in their home endanger their health, safety or welfare. On an even more practical level, Assembly 9959 (Brennan) would appropriate $5 million toward the cost of providing air conditioning for adult home residents, a substantial percentage of whom do not have air conditioned rooms. During the past summer of record-setting heat, there was a 13 percent increase in deaths among adult home residents, many of whom are elderly and/or mentally ill and especially susceptible to extreme heat.

Mental Health Planning: Several proposals are under consideration that would require the State to examine its approach to mental health services in a more systematic way. For example, Senate 6672 (Morahan)/Assembly 9649 (Rivera) would establish a children's mental health

advisory board that would be charged with the responsibility for preparing and monitoring the implementation of a children's mental health plan, including a plan for the integration of social and emotional development into elementary and secondary school educational programs. To address issues relating to the Governor's intention of mandating managed care enrollment of Medicaid beneficiaries who suffer from serious and persistent mental illness (SPMI), the New York State Coalition of Prepaid Health Services Plans has advanced a proposal that would require the convening of a workgroup of stakeholders to examine the special needs of this vulnerable population and to recommend strategies to ensure continued health care access and effective care for this population.

In a similar vein, legislators have questioned whether the Commission on Health Care Facilities in the Twenty-First Century (a.k.a. "the Hospital Closing Commission") has adequately considered issues relating to the provision of mental health and substance abuse services as it approaches its important tasks. The proposal, Assembly 10186 (Espaillat)/Senate 6591 (Paterson) would require the Commissioners of OMH and OASAS to participate in the Commission's work and would require the Commission to give due consideration to the ambulatory care, mental health care and substance abuse service needs of the New York State population before making its recommendations.

Civil Confinement of Sexual Offenders: Another extremely intense debate has occurred over the past several years over how the correctional and mental health systems should address certain persons who have been convicted of sexual crimes who may be determined to be appropriate for civil commitment. Under a Senate proposal, Senate 6325 (Volker), a procedure would be instituted to review, prior to the release of the convicted sexual offender, whether the offense was "sexually motivated" and, as such, whether the offender is a "sexually violent predator." In such a case, the offender would then be subject to being civilly committed in a secure treatment facility. An Assembly proposal, Assembly 9282 (Silver), would also order civil commitment in cases in which the offender is determined to be a sexual predator who is likely to repeat the offense. The Assembly bill would also preclude these sexual predators from coming into contact with non-offenders within the state psychiatric facility in which they may be confined.

Even without any legislative agreement, the Pataki Administration has taken steps to seek civil commitment, under existing statutes, of sex offenders as they approach the end of their prison terms. According to the New York State Psychiatric Association, 21 out of 78 sexually violent predators being released were deemed appropriate for civil commitment and were committed to state psychiatric centers. A recent decision in a case brought on behalf of these offenders, challenging their commitment, is discussed in the "In the New York State Courts" column in this edition. Even more recently, that case was reversed by the Appellate Division (*State (Harkavy) v. Consilvio*, 2006 NY Slip Op 2451 (1st Dept. March 30, 2006)), which dismissed the challenge by the sexual offenders to their involuntary commitment and upheld OMH's psychiatric hospitalization of these offenders pursuant to the process set forth in the Mental Hygiene Law that is generally applicable to the general public, rather than requiring the more extensive due process to which prisoners are entitled.

Mr. Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP. **Mr. Lytle would like to acknowledge the assistance of his colleague from that office, Karen Lipson, with the preparation of this article.**

In the New York State Agencies

By Frank Serbaroli

HEALTH DEPARTMENT

Adult Care Facility Inspection Reports

Notice of adoption. The Department of Health amended provisions of §§ 486.2 and 486.5 of Title 18 N.Y.C.R.R. to require the Department's inspection reports to identify whether each area of operation of an adult care facility is in compliance with regulations. Filing date: October 11, 2005. Effective date: October 26, 2005. *See* N.Y. Register, October 26, 2005.

Health Provider Network Access and Reporting Requirements for Articles 28, 36 and 40 Facilities

Notice of adoption. The Department of Health amended §§ 400.10, 763.11, 766.9 and 793.1 of Title 10 N.Y.C.R.R. to require Article 28 facilities (hospitals), Article 36 facilities (home care agencies) and Article 40 facilities (hospices) to establish and maintain health provider network accounts with the Department of Health for the purpose of exchanging information with the Department in a rapid, efficient manner in times of emergency or urgent matters. Filing date: October 13, 2005. Effective date: November 2, 2005. *See* N.Y. Register, November 2, 2005.

Health Provider Network Access and Reporting Requirements

Notice of adoption. The Department of Health amended §§ 487.12, 488.12 and 490.12 of Title 18 N.Y.C.R.R. to require adult homes, enriched housing programs and residences for adults to establish and maintain health provider network accounts with the Department of Health for the purpose of exchanging information with the Department in a rapid, efficient manner in times of emergencies or urgent matters.

Filing date: October 13, 2005. Effective date: November 2, 2005. *See* N.Y. Register, November 2, 2005.

Laboratory Confirmed Influenza

Notice of adoption. The Department of Health amended § 2.1 of Title 10 N.Y.C.R.R. to add laboratory confirmed influenza to the communicable disease reporting list to enable the Department of Health to have more comprehensive and complete information on influenza cases and permit the State and local health departments to channel limited vaccines, anti-viral agents and public health resources to those in greatest need during an influenza outbreak. Filing date: October 13, 2005. Effective date: November 2, 2005. *See* N.Y. Register, November 2, 2005.

Statewide Perinatal Data System

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add § 400.22 to Title 10 N.Y.C.R.R. to establish a State Perinatal Data System to provide useful data on the births and maternal health for perinatal care providers and the Department of Health and promote expedited Medicaid eligibility determinations for newborns. *See* N.Y. Register, November 16, 2005.

Part-Time Clinics

Notice of adoption. The Department of Health amended §§ 703.6 and 710.1 of Title 10 N.Y.C.R.R. to clarify and enhance the requirements that apply to part-time clinics and require prior limited review of all part-time clinic sites in order to ensure the provision of quality health care to underserved populations through preventive health screening programs and other public health initiatives. Filing date: November 8, 2005. Effective date: November 23, 2005. *See* N.Y. Register, November 23, 2005.

Newborn Screening

Notice of adoption. The Department of Health amended §§ 69-1.1, 69-1.2 and 69-1.3 of Title 10 N.Y.C.R.R. to add thirty-three inherited metabolic disorders to the current New York State newborn screening test panel. Filing date: November 8, 2005. Effective date: November 23, 2005. *See* N.Y. Register, November 23, 2005.

Spousal Impoverishment Budgeting

Notice of adoption. The Department of Health revised § 360-4.10(a)(9) of Title 18 N.Y.C.R.R., the Medicaid regulations, to clarify that in determining Medicaid eligibility for an institutionalized spouse, a community spouse's pension fund or individual retirement account is a countable resource. Filing date: December 1, 2005. Effective date: December 21, 2005. *See* N.Y. Register, December 21, 2005.

Adult Care Facility Regulations

Notice of adoption. The Department of Health amended §§ 486.4 and 493.2 of Title 18 N.Y.C.R.R. to conform with the Social Services Law, which allows for an adult care facility operating certificate to be suspended or limited without a hearing for a maximum of 60 days. Filing date: December 20, 2005. Effective date: January 4, 2006. *See* N.Y. Register, January 4, 2006.

New York State AP-DRGs, Service Intensity Weights and Group Average Arithmetic Inlier Lengths of Stay

Notice of emergency rulemaking. The Department of Health amended §§ 86-1.62 and 86-1.63 of Title 10 N.Y.C.R.R. to update the current regulations to make them consistent with changes made to the diagnosis-related group (DRG) classification system used by the Medicare prospective payment system and to modify existing DRGs and add new DRGs to more accurately reflect the use of health resources. Filing date: December 30, 2005. Effective date: January 1, 2006. *See* N.Y. Register, January 18, 2006.

Nursing Home Pharmacy Regulations

Notice of emergency rulemaking. The Department of Health amended § 415.18(g) and (i) of Title 10 N.Y.C.R.R. to make a wider variety of medications available in nursing home emergency kits and to allow verbal orders from legally authorized practitioners in order to respond quickly to the needs of nursing home residents. Filing date: January 9, 2006. Effective date: January 9, 2006. *See* N.Y. Register, January 25, 2006.

Serialized Official New York State Prescription Form

Notice of emergency rulemaking. The Department of Health added Part 910 and amended §§ 84.84, 85.21, 85.22, 85.23 and 85.25 of Title 10 N.Y.C.R.R. and amended §§ 505.3, 528.1 and 528.2 of Title 18 N.Y.C.R.R. to enact an official New York State prescription form to deter fraud by curtailing theft or copying of prescriptions by individuals engaged in drug diversion. The regulations also define the requirements for using the official prescription form and provide for an 18-month period where both existing prescription forms and the official prescription forms can be used to allow for a transitional period for practitioners, institutions and pharmacists. Filing date: January 13, 2006. Effective date: January 13, 2006. *See* N.Y. Register, February 1, 2006.

Expansion of the New York State Newborn Screening Panel

Notice of emergency rulemaking. The Department of Health amended § 69-1.2 of Title 10 N.Y.C.R.R. to add one condition (galactosylceramidase deficiency or Krabbe disease) to the current New York State newborn screening test panel. Filing date: January 18, 2006. Effective date: January 18, 2006. *See* N.Y. Register, February 8, 2006.

INSURANCE DEPARTMENT

Healthy New York Program

Notice of emergency rulemaking. The Department of Insurance added § 362-2.7 and amended §§ 362-2.5, 362-3.2, 362-4.1, 362-4.2, 362-4.3, 362-5.1, 362-5.2, 362-5.3, and 362-5.5 of Title 11 N.Y.C.R.R. in order to increase the insurance coverage of uninsured workers employed by small businesses, by reducing cost, lessening complexity, and adding a second benefit package to the Healthy New York Program. Filing date: November 30, 2005. Effective date: November 30, 2005. *See* N.Y. Register, December 21, 2005.

Rules Governing Individual and Group Accident and Health Insurance Reserves

Notice of emergency rulemaking. The Department of Insurance repealed Part 94 and added a new Part 94 (Regulation 56) to Title 11 N.Y.C.R.R. to prescribe rules and regulations for the valuation of minimum individual and group accident and health insurance reserves, including standards for valuing certain accident and health benefits in life insurance policies and annuity contracts. Filing date: January 6, 2006. Effective date: January 6, 2006. *See* N.Y. Register, January 25, 2006.

Compiled by Francis J. Serbaroli. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft LLP's 15-attorney health law department. He is the Vice Chairman of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and serves on the Executive Committee of the New York State Bar Association's Health Law Section. He is the author of "The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care," published by BNA as part of its Business and Health Portfolio Series. The assistance of Vimala Devassy and Stephanie Marcantonio of Cadwalader, Wickersham & Taft LLP, in compiling this summary is gratefully acknowledged.

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- *The Dietary Supplement Health and Education Act: Regulation at a Crossroads*
  - *Foreword: Dietary Supplement Regulation In Flux*, Barbara A. Noah
  - *FDA Statutory Authority to Regulate the Safety of Dietary Supplements*, Peter Barton Hutt
  - *Science, Politics, and the Regulation of Dietary Supplements: It's Time to Repeal DSHEA*, Peter J. Cohen
  - *Dietary Supplement Labeling: Cognitive Biases, Market Manipulation & Consumer Choice*, Michael A. McCann
  - *What Lies Beneath: An Examination of the Underpinnings of Dietary Supplement Safety Regulation*, Dana Ziker
  - *The New Dietary Ingredient Safety Provision of DSHEA: A Return to Congressional Intent*, Scott Bass & Emily Marden
  - *Functional Foods: What Are They? How Are They Regulated? What Claims Can be Made?*, Martin Hahn
  - *Dietary Supplements: A Definition that is Black, White, and Gray*, Suzan Onel
  - *Quackery*, Maxwell J. Mehlmen
- *Potential Interactions of the Orphan Drug Act and Pharmacogenomics: A Flood of Orphan Drugs and Abuses?*, David Loughnot
- *The Role of State Regulation in Consumer-Driven Health Care*, Timothy S. Jost & Mark A. Hall
- *Lessons Across the Pond: Assisted Reproductive Technology in the United Kingdom and the United States*, Alicia Ouellette et al.
- *Prison Health, Public Health: Obligations and Opportunities*, John V. Jacobi
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- *The Presidents' Mental Health*, Kirath Raj

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- *Law, Medicine, and Religion: Towards a Dialogue and a Partnership in Biomedical Technology and Decision Making*, George P. Smith
- *Community Housing Trust: A Fair Standard for the Fair Housing Amendments Act*, Daniel F. Cardile
- *Forced Medication of Criminal Defendants and the Unintended Consequences of* Sell v. United States, Richard Glasgow

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  - *Introduction*, Stephan Landsman
  - *Reforming Medical Malpractice in a Radically Moderate—and Ethical—Fashion*, Paul C. Weiler
  - *Binding Statutory Early Offers by Defendants, Not Plaintiffs, in Personal Injury Suits*, Jeffrey O'Connell & Evan Stephenson
  - *Public Medical Malpractice Insurance: An Analysis of State-Operated Patient Compensation Funds*, Frank A. Sloan et al.

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- *The States "Race" with the Federal Government for Stem Cell Research*, Joanna K. Sax
- *Conscience Clauses and Oral Contraceptives: Conscientious Objection or Calculated Obstruction?*, Mary K. Collins
- *Is Obesity Really the Next Tobacco? Lessons Learned from Tobacco for Obesity Litigatio*n, Brooke Courtney
- *Drug Deals in 2006: Cutting Edge Legal and Regulatory Issues in the Pharmaceutical Industry*, Jonathan K. Henderson & Quintin Cassady
- *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, William P. Gunnar

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- *The Offshoring of American Medicine: Scope, Economic Issues, and Legal Liabilities*, Thomas R. McLean
- *The Effect of Hospital Charges on Outlier Payments under Medicare's Inpatient Prospective Payment System: Prudent Financial Management or Illegal Conduct?*, R. Brent Rawlings
- *The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State*

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- *Pharmaceutical Cost Management and Access to Psychotropic Drugs: The U.S. Context*, H. A. Huskamp
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- *Treatment of the "Vegetative" Patient: The Legacies of Karen Quinlan, Nancy Cruzan and Terri Schiavo*, Maura A. Flood
- *Guidelines for Informed Decision-making Governing Cochlear Implants in Minors*, Lynne A. Morrison

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- *Reforming Residency: Modernizing Resident Education and Training to Promote Quality and Safety in Healthcare*, B. A. Liang & L. Lin
- *Law and Public Health: Beyond Emergency Preparedness*, W. K. Mariner
- *The National Response Plan: A New Framework for Homeland Security, Public Health, and Bioterrorism Response*, B. Kamoie
- *The Statute of Security: Human Rights and Post-9/11 Epidemics*, George J. Annas

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- *Symposium: Expert Testimony: Bridging Bioethics and Evidence Law*
  - *Introduction: Bioethics in Court*, Ben A. Rich
  - *Expert Testimony by Ethicists: What Should Be the Norm?*, Edward J. Imwinkelried
  - *Bioethics Testimony: Untangling the Strands and Testing Their Reliability*, Bethany J. Spielman
  - *Imwinkelried's Argument for Normative Ethical Testimony*, David W. Barnes
  - *Expert Bioethics Testimony*, Stephen R. Latham
  - *Is There Any Indication for Ethics Evidence? An Argument for the Admissibility of Some Expert Bioethics Testimony*, Lawrence J. Nelson
  - *The Roles of Ethicists in Managed Care Litigation*, Mary Anderlik Majumder
  - *Ethics Expertise in Civil Litigation*, Kenneth Kipnis
  - *California's Proposition 69: A Dangerous Precedent for Criminal DNA Databases*, Tania Simoncelli & Barry Steinhardt
  - *Dying in America—An Examination of Policies that Deter Adequate End-of-Life Care in Nursing Homes*, Diane E. Hoffmann & Anita J. Tarzian
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  - *Off with Their Heads: The Need to Criminalize Some Forms of Scientific Misconduct*, Barbara K. Redman & Arthur L. Caplan
  - *Physician-Assisted Suicide and Criminal Prosecution: Are Physicians at Risk?*, Stephen J. Ziegler
  - *Terri Schiavo and the Roman Catholic Tradition of Forgoing Extraordinary Means of Care*, Daniel P. Sulmasy
  - *Facts, Lies, and Videotapes: The Permanent Vegetative State and the Sad Case of Terri Schiavo*, Ronald Cranford
  - *Currents in Contemporary Ethics: "Family" in Advance Care Planning: The Family Covenant in the Wake of Terri Schiavo*, David John Doukas
  - *The Ethical Health Lawyer: Maintaining Integrity While Representing Health Care Clients Under Investigation or Before a Tribunal*, Philip L. Pomerance
  - *Reviews in Medical Ethics: Refining Humanity: A Review of the Coevolution of Human Potential and Converging Technologies*, Michael Clisham
  - *Recent Developments in Health Law:*
    - *Recent Developments in the Law and Ethics of Embryonic Research: Can Science Resolve the Ethical Problems It Creates?*, Christopher Robertson
    - *The Latest Face of Medical Review Panels in Wyoming*, Jackie Cohen
    - *Pharma's Commitment to Maintaining a Clinical Trial Register: Increased Transparency or Contrived Public Appeasement?*, Benjamin Falit
    - *U.S. Supreme Court Hears Oral Arguments in* Ashcroft v. Raich Background, Catherine Laughlin
    - *Drug Companies Offer Major Discounts to Uninsured*, Vonn Christenson

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- *Pesticides, Children's Health Policy, and Common Law Tort Claims*, Alexandra B. Klass
- *Frontiers of Medical Technology: Reflections on the Intersection of Innovation and the Health Care System*, Susan B. Foote
- *Patient Expectations and Access to Prescription Medication Are Threatened by Pharmaceutical Conscience Clause*, Kelsey C. Brodsho

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  - *Introduction*, Rebecca C. Morgan & Michael P. Allen
  - *Felos on Schiavo*, George Felos
  - *Gibbs on Schiavo*, David C. Gibbs, III
  - *Connor on Schiavo*, Kenneth Connor
  - *The Rule in Terri's Case: An Essay on the Public Heath of Theresa Marie Schiavo*, Jay Wolfson
  - *"I Want To Live": Medicine Betrayed by Ideology in Political Debate Over Terri Schiavo*, George J. Annas
  - *Déjà vu All Over Again: The False Dichotomy Between Sanctity of Life and Quality of Life*, Norman L. Cantor
  - *Schaivo and Its (In)Significance*, John A. Robertson
  - *Erring Too Far on the Side of Life: Déjà Vu All Over Again: The Schiavo Saga*, William Allen
  - *Tracking the Storm: The Far-Reaching Powers of the Forces Propelling* Schiavo *Cases*, Kathy L. Cerminara
  - *Terri's Law and Democracy*, Michael P. Allen
  - *A Dissenting Opinion*, Bush v. Schiavo, 855 So. 2d 321 (Fla. 2004), Thomas C. Marks, Jr.

***Trial*, Vol. 14, No. 10 (Oct. 2005)**

- *Ensure Justice in Nursing Home Cases*, M. M. Eastman
- *Straight Talk About Health Care*

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- *Major Hospitals Agree to Stop Overbilling Uninsured Patients*, S. H. Jurand

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- *QALYs and Policy Evaluation: A New Perspective*, Matthew D. Adler
- *Managed Process, Due Care: Structures of Accountability in Health Care*, Nan D. Hunter
- *Does "Reparative" Therapy Really Constitute Child Abuse?: A Closer Look*, Sean Young
- *Medical Licensure, Peer Review, and the National Practitioner Data Bank*, William P. Gunnar
- *An Appropriate Legislative Response to Cloning for Biomedical Research: The Case Against a Criminal Ban*, Adam Gusman
- *Fourth Annual Health Law Colloquium: Oh, Darling! 40 Years Later: The Legacy of* Darling v. Charleston Community Memorial Hospital *and the Evolution of Hospital Liability*
  - Darling v. Charleston Community Hospital *and Its Legacy*, Mitchell J. Wiet
  - *A New Quality Challenge: Coordinating Credentialing and Corporate Compliance*, Mark A. Kadzielski
  - *New Governance Norms and Quality of Care in Nonprofit Hospitals*, Thomas L. Greaney
  - *Looking at Accountability 40 Years After* Darling, Nathan Hershey & Christine M. Jarzab

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- *Abortion: When Choice and Autonomy Conflict*, Jennifer Denbow, 20 Berkley J. Gender L. & Just. 216 (2005)
- *Aging in Today's Environment: Is It a Healthy Proposition?*, Jacqueline A. Olexy, 14 Penn St. Envtl. L. Rev. 131 (2005)
- *An Analysis of Recent ERISA Preemption Jurisprudence in Anticipation of Cigna Healthcare of Texas v. Calad and Aetna Health, Inc. v. Davila*, 19 St. John's J. Legal Comment 535 (Summer 2005)
- *Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability's Doctrinal Ambiguity*, Hyun J. Son, 14 UCLA Women's L.J. 213 (2005)
- *Bad Moon Rising: The Dark Side of Medicare Part D and Medigap*, J.J. Campbell, 34 The Colorado Lawyer 1243 (Oct. 2005)

- *Childhood Obesity, Baby Boomers, and the Echo Boom*, Elizabth Cleary, 7 Marq. Elder's Advisor 137 (2005)
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- *ERISA Liability for Provision of Medical Information*, Kristin Madison, 48 N.C. L. Rev. 471 (2006)
- *Facility Liability for Damage or Destruction of Cryopreserved Embryos—A Medical and Legal Analysis*, J. Storch, 52 Med. Trial Tech. Q. 233 (2005)
- *The Federal Government's Failure to Provide Health Care to Urban Native Americans in Violation of The Indian Health Care Improvement Act*, Beverly Graleski, 82 U. Det. Mercy L. Rev. 461 (2005)
- *Fighting Epidemics with Information and Laws: The Case of SARS in China*, Vincent R. Johnson & Brian T. Bogley, 24 Penn. St. Int'l L. Rev. 157
- *Gauging the Cost of Loopholes: Health Care Pricing and Medicare Regulation in the Post-Enron Era*, Elizabeth A. Weeks, Wake Forest Law Review, Volume 40 (2005)
- *Going After the "Hired Guns": Is Improper Expert Witness Testimony Unprofessional Conduct or the Negligent Practice of Medicine?*, Jennifer Turner, 33 Pepp. L. Rev. 275 (2006)
- *The Evolution of the "Patent": Shifts in Attitudes about Consent, Genetic Information, and Commercialization in Health Care*, Janet L. Dolgin, 34 Hofstra L. Rev. 137 (2005)
- *HMOs Behind Bars: Constitutional Implications of Managed Health Care in Prison Systems*, Richard Siever, 58 Vand. L. Rev. 1365 (2005)
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- *The Maternal-Fetus Conflict: The Right of a Woman to Refuse Caesarian Sections Versus the State's Interest in Saving the Life of the Fetus*, Daniel R. Levy, 108 W. Va. L. Rev. 97 (2005)
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- *Patented Embryonic Stem Cells: The Quintessential "Essential Facility"?*, Amy R. Davis, 94 Geo. L.J. 205 (2005)
- *Poor on Paper: An Overview of the Ethics and Morality of Medicaid Planning*, J.S. Karp & S.I. Gershbein, 79 Fla. Bar J. 61 (Oct. 2005)
- *Quests for Conception: Fertility Tourists, Globalization the Feminist Legal Theory*, Richard F. Storrow, 57 Hastings L.J. 295 (2005)
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- *Refusal Clauses and the Weldon Amendment: Inherently Unconstitutional and a Dangerous Precedent*, J. Green, 26 J. Legal Med. 401 (Sept. 2005)
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This issue's "In the Journals" column was assembled by Adrienne Foederer, a law student at Albany Law School.

For Your Information

By Claudia O. Torrey

The Enforcement Final Rule ("Rule") for the Health Information Portability and Accountability Act (HIPAA) was published in the Federal Register on Thursday, February 16, 2006, by the Department of Health and Human Services (HHS).[1] The Rule applies to all of the HIPAA, not just to the privacy standards; civil money penalties on covered entities (CE) are instituted, and the HHS Department revises existing rules that relate to compliance with, and enforcement of, the HIPAA rules. The effective date for the Rule was March 16, 2006.

The Rule provides for a person to file a complaint with the HHS Secretary in writing (on paper or electronically) when there is belief that a CE is not complying with the administrative simplification provisions.[2] A person is defined as a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.[3] The complaint must be descriptive of the acts and/or omissions, and do so within 180 days of when the complainant knew or should have known that the act or omission complained of occurred, unless such is waived for good cause by the HHS Secretary.[4]

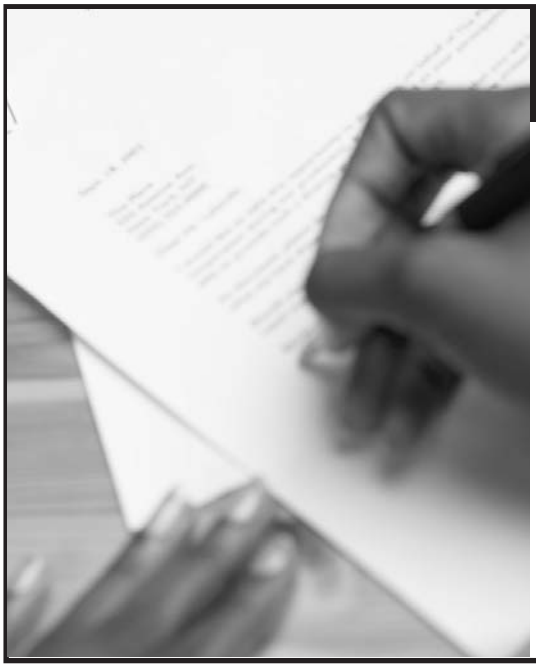
Civil money penalties may be imposed as follows: no more than $100 for each violation, or not in excess of $25,000 for identical violations during a calendar year (January 1 through December 31).[5] A CE that is a member of an affiliated CE is jointly and severally liable, unless it is established that another member of the affiliated CE is responsible for the violation(s).[6] A CE is liable for a violation of any agent, workforce member, etc., who is acting within the scope of the agency, unless the agent is a business associate (BA), **and** the CE is in compliance regarding the BA, **and** the CE neither knew of any non-complying activity by the BA, nor failure to act by such BA.[7] The Rule also lists potential aggravating and mitigating factors, as well as affirmative defenses.[8]

There are respondent procedures for a hearing before an administrative law judge,[9] and the Statute of Limitations for the Rule is six years. That is, no enforcement action may be entertained unless commenced by the HHS Secretary within six years from the date of the occurrence of the violation.[10]

Endnotes

1. 71 FR 8390–8433 (HIPAA Administrative Simplification: Enforcement; Final Rule) (to be codified at 45 C.F.R. part 160, subparts C, D, and E).
2. 45 C.F.R. § 160.306; the CE is also referred to as the respondent.
3. 45 C.F.R. § 160.103.
4. *Id.*
5. 45 C.F.R. § 160.404.
6. 45 C.F.R. § 160.402(b)(2).
7. 45 C.F.R. § 160.402(c).
8. 45 C.F.R. §§ 160.408, 160.410.
9. 45 C.F.R. § 160.500–160.552.
10. 45 C.F.R. § 160.414.

Claudia O. Torrey, Esq. is a member of several professional organizations, including a Sustaining Member of the New York State Bar Association.



Request for Articles

If you have written an article and would like to have it considered for publication in the ***Health Law Journal***, please submit it to:

Robert N. Swidler, Esq.
Northeast Health
2212 Burdett Avenue
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e-mail: swidlerr@nehealth.com

Articles should be submitted in Microsoft Word or WordPerfect, along with a printed original and biographical information.

Introduction to Special Edition: Selected Topics in Mental Health Law

By Henry Dlugacz, Special Edition Editor

The field of Mental Health Law as we know it did not exist prior to the 1970s. Courts which did entertain cases involving people with mental disabilities were often unsympathetic, not just to the individuals themselves, but to the legal underpinnings of their claims. For example, as recently as 1960, the Iowa Supreme court held in *Prochaska v. Brinegar*[1] that the Fourteenth Amendment's due process clause was not implicated when the state wished to confine a person to a psychiatric hospital against his will—a notion which seems counterintuitive to us today and was specifically rejected by the Supreme Court in *O'Connor v. Donaldson*.[2]

During the past forty years, a reasonably coherent, remarkably diverse and ever-evolving body of law has developed, so that now courses on mental health issues are taught in approximately 110 out of 180 law schools around the country. This should not be surprising as people with mental disabilities engage in the full range of human activities which are subject to legal regulation. They are employees and employers, doctors and patients, law-breakers and attorneys. They seek treatment and resist treatment; they are young and old.

The New York State Legislature in Article 81 of the Mental Hygiene Law expressed this notion quite eloquently when it said: "The legislature hereby finds that the needs of persons with incapacities are as diverse and complex as they are unique to the individual."[3]

The issues which grow out of this complexity continue to resonate today, encompassing some of the most intriguing legal and policy issues we face in New York State. Even a cursory review of the *New York Law Journal* or the daily newspaper should make this clear.

- Should we have a statute to civilly commit sexual predators?
- Does the practice of transferring patients from psychiatric hospitals to New Jersey nursing homes meet constitutional and statutory muster?
- Should "Kendra's Law" be made a permanent part of the Mental Hygiene Law?
- Should the Assembly and Senate pass legislation to regulate the placement of mentally ill prisoners in punitive segregation?
- Should it be legal for health insurers to provide lower levels of coverage for mental health issues than they do for other conditions?

These are just a few of the important issues before our courts and Legislature which fall under the rubric of "Mental Health Law."

As you read this issue you will find articles describing innovative ways of dealing with mentally ill criminal defendants, issues which arise when a student with a mental disability attends a university, or when family members seek to obtain needed treatment for a loved one. Another article gives useful advice concerning the often vexing issue of consent to treatment for a juvenile patient, while others deal with important matters such as funding formulae used by the State to finance outpatient mental health care, or the estate planning issues which arise for a person with a mental disability.

I am exceedingly grateful to the distinguished authors who took time out of their busy schedules to contribute articles to this edition. Their articles further highlight the fascinating ways in which Mental Health Law has become an integral part of civil and criminal practice in New York State. They are: Marcia J. Boyd, Esq.; The Honorable Matthew J. D'Emic; Justin Frazer, Esq.; Lydia Hoffman Meunier, Esq.; Carolyn Reinach Wolf, Esq.; J. David Seay, Esq.; Douglas K. Stern, Esq.; and Pamela Tindall-O'Brien, Esq. I am also grateful to *Health Law Journal* Editor Robert Swidler, Esq., who provided many useful suggestions along the way.

This area of specialization has come a long way in a short time. If these articles spark your interest, please consider joining the Health Law Section of the State Bar Association, and its Committee on Mental Health Issues which I co-chair with J. David Seay.

Endnotes

1. 251 Iowa 834, 102 N.W.2d 870, 872 (1960).
2. 422 U.S. 563 (1975).
3. N.Y. Mental Hyg. Law § 81 (McKinney 1996).

Warm regards,
Henry A. Dlugacz

An Attorneys' Guide to Counseling Clients Utilizing the Mental Health System

By Carolyn Reinach Wolf and Douglas K. Stern

Introduction

On April 29, 2002, President George W. Bush created the President's New Freedom Commission on Mental Health. In a letter to the President, Michael F. Hogan, Ph.D., the Chairman of the Commission, wrote,

> [a]fter a year of study, and after reviewing research and testimony, the Commission finds that recovery from mental illness is now a real possibility. The promise of the New Freedom Initiative—a life in the community for everyone—can be realized. Yet, for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic—the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

Caring for individuals with mental illnesses will be one of the greatest healthcare challenges our society must face over the next several decades.

The last half-century of mental health care in New York has been defined by the deinstitutionalization of the mentally ill and a focus on treatment in the community. Vigorous debate will continue as to whether or not state lawmakers, health care providers and our courts have meaningfully responded to the challenges faced by this shifting paradigm. In the year 2000, an estimated 1.9 million adult New York State residents were identified as either having a Serious Mental Illness (SMI), illicit drug dependence or co-occurring disorders.[1] This number, over the past five years, has actually proven to be considerably higher. In 1955 there were 93,197 adults residing in 20 state-run psychiatric centers; as of October 1, 2003, there was a total census of 4,233 people residing in 17 adult psychiatric care centers.

The overwhelming number of individuals struggling with a mental illness generally seek treatment either in an acute care psychiatric facility or from community-based treatment providers. Few people contend that the state's financial resources are sufficient to meet demand. Furthermore, with decreasing private insurance coverage, increasing costs for medications and the re-prioritization of resources in tight economic times, comes an enormous challenge in creating effective community-based treatment plans. To compound the problem, what do treatment providers and families do if their mentally ill patient, relative or loved one refuses or is non-compliant with treatment in the community? One answer is they often call a lawyer.

But what is a lawyer to do? There are options. This article will provide a broad overview of the resources available to attorneys and families faced with the challenge of an individual who is afflicted with a mental illness and either refuses or is unable to cooperate with treatment. The possibilities range from community intervention programs to psychiatric commitment at a short-term "acute" hospital to Assisted Outpatient Treatment, known as "Kendra's Law."

Community Intervention Programs (Non-Judicial)

More often than not when an individual is exhibiting signs of his/her mental illness due to a first break, non-compliance with or refractory to treatment (in psychiatric terms—decompensation), their willingness to partake in a clinical intervention is slim to nil. This assumption being made, the following paragraphs will outline some of the resources that attorneys and families can access to initiate interventional care for their loved one or institute a plan of care to maintain their loved one in the community once they are psychiatrically stable.

The Mobile Crisis Team—A mobile crisis team is a multi-disciplinary conglomerate of professionals and para-professionals. These teams may include: psychiatrists, psychologists, social workers, addiction counselors and therapy aides. The New York City Department of Health and Mental Hygiene advises that Mobile Crisis Teams are indicated when a person, "is experiencing, or is at risk of, a psychological crisis, and who requires mental health intervention and follow up

support to overcome resistance to treatment." While the administration of Mobile Crisis Teams may vary by county, generally they are administered by a voluntary agency or a municipal hospital. Anyone can initiate a report to the Mobile Crisis Team and the Team may respond to the subject's home, work or another location. If a determination is made by the Mobil Crisis Team that immediate observation and care are essential for the subject's welfare, they can activate the police/EMS and have the individual brought to an appropriate General Emergency or Psychiatric Emergency Room of a hospital.

Assertive Community Treatment Team—The Office of Mental Health best summarizes the Assertive Community Treatment (ACT) Team as a form of case management that is distinguished from more traditional case management by several important features. First, rather than a case manager coordinating services, an ACT multi-disciplinary team provides services directly to an individual that are tailored to meet his/her specific needs. An ACT team typically includes members from one of the fields of psychiatry, such as nursing, psychology, and social work with increasing involvement of substance abuse and vocational rehabilitation specialists. Based on their various areas of expertise, the team members collaborate to deliver integrated services of the recipient's choice, monitor progress towards goals, and adjust services over time to meet the recipient's changing needs. The staff-to-recipient ratio is small (one clinician for every 10 recipients versus 1 clinician for every 30 recipients in traditional case management) and services are provided 24 hours a day, 7 days a week, for as long as they are needed. ACT teams deliver comprehensive and flexible treatment, support, and rehabilitation services to individuals in their natural living settings. This means that interventions are carried out at the locations where problems occur and support is needed rather than in hospital or out-patient settings. ACT teams share responsibility for the people they serve and use assertive engagement to proactively engage individuals in treatment.

To be clear, an ACT team will generally not get involved when an individual is in an acutely decompensated state and in need of immediate in-patient care. The ACT team is initiated mostly in situations where a person is relatively stable, with some insight and is likely to comply with treatment in the community, but requires an intensive level of supervision and treatment. The ACT team is often incorporated as part of a Kendra's Law (AOT) treatment plan.

Intensive Case Management—Similar to the ACT team, Intensive Case Management (ICM) is targeted at individuals with relative psychiatric stability. The New York City Department of Health and Mental Hygiene (NYCDHMH) lists its criteria for Intensive Case Management as follows:

> Eligible clients must have a diagnosable mental illness that impairs functions in several essential areas of life, including self care, social functioning, activities of daily living, economic self sufficiency, self direction and concentration. Target groups include (1) high risk/heavy users of inpatient units, emergency and crisis centers, (2) extended care state psychiatric center patients, and (3) individuals with serious, persistent mental illnesses who also are homeless.

While criteria may vary from county to county, the NYCDHMH guidelines are useful and have general applicability.

The NYCDHMH advises that,

> Intensive case management services are delivered in the community, and programs have a low staff to client ratio. Services are not time-limited. Intensive case managers conduct outreach to engage clients; monitor and coordinate the delivery of evaluations and assessments and participate in the development of an individualized, goal-oriented services plan; provide assistance in crisis intervention and stabilization; assist clients through on-going support, training and assistance in the use of personal and community resources; assist in developing a range of community and family supports; advocate for changes in the system. Intensive case management services are available 24 hours a day, 7 days a week, 365 days a year.

The ICM is another option that is often incorporated as part of a Kendra's Law (AOT) order.

Partial Hospitalization Programs—Partial hospitalization programs provide active treatment designed to stabilize and ameliorate acute symptoms, to serve as an alternative to in-patient hospitalization, or to reduce the length of hospital stay within a medically supervised program.[2] Eligibility for admission to a partial hospitalization program is based on a designated mental illness diagnosis which has resulted in dysfunction due to

acute symptomatology and requires medically supervised intervention to achieve stabilization and which, but for the availability of a partial hospitalization program, would necessitate admission to or continued stay in an in-patient hospital.[3] Services include assessment, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, psychiatric rehabilitation readiness determination and referral, crisis intervention services, activity therapy and clinical support services.[4]

The Psychiatric Commitment

There may come a time when an individual is too ill to reside in the community and requires acute psychiatric hospitalization. The terms voluntary, involuntary and emergency, relate to the willingness and understanding of an individual to accept care and treatment in a psychiatric facility on a short-term or "acute" basis and the hospital's obligation to provide care and treatment. The following is a discussion of the general differences between these various types of admission status.

It should be noted that a hospital, upon a patient's admission (regardless of status), must inform the patient in writing of his or her status and rights under Article 9 of the Mental Hygiene Law, including the availability of the Mental Hygiene Legal Service (MHLS), the appointed legal counsel for patients in psychiatric facilities.

The Voluntary Admission

Article 9 explicitly encourages voluntary admissions over the involuntary admission by providing that a "person requesting admission to a hospital, who is suitable for admission on a voluntary . . . status, shall be admitted only on such a voluntary . . . status." Article 9 states that a hospital may admit as a voluntary patient "any suitable person in need of care and treatment, who voluntarily makes written application for admission." The statute defines "in need of care and treatment" broadly as meaning "that a person has a mental illness for which in-patient care and treatment in a hospital is appropriate." Under the statute, a person is "suitable" for admission as a voluntary patient if he or she is notified of and, despite his or her mental illness, has the ability to understand the following three fundamentals regarding his or her admission to the hospital: (1) "that the hospital to which he is requesting admission is a hospital for the mentally ill," (2) "that he is making an application for admission," and (3) "the nature of voluntary . . . status, . . . and the provisions governing release or conversion to involuntary status."

The consumer should be clear that voluntary admission status does not equate to an ability to leave the hospital at will. There is a process by which a voluntary patient may seek release from a psychiatric hospital and/or a hospital may seek to retain a voluntary patient against his/her wishes. Article 9 provides that:

> If [a] voluntary patient gives notice in writing to the director [of the hospital] of the patient's desire to leave the hospital, the director shall promptly release the patient; provided, however, that if there are reasonable grounds for belief that the patient may be in need of involuntary care and treatment, the director may retain the patient for a period not to exceed seventy-two hours from receipt of such notice. Before the expiration of such seventy-two hour period, the director shall either release the patient or apply to . . . court . . . for an order authorizing the involuntary retention of such patient.

The written notice of the patient's desire to leave the hospital is commonly referred to as a "72-hour letter" because it triggers the hospital's obligation to either discharge the patient or seek court authorization to retain the patient on involuntary status within 72 hours of the patient's submission of the notice. There are no formal requirements for the notice, other than that it be written by the patient and that it request release from the hospital. The patient may give the notice to any member of the treatment team. Article 9 provides that in the event the hospital applies for a court order to retain a patient who has submitted a 72-hour letter, the hearing must by held within three days of the date the court receives the hospital's application. (Practically speaking, the hearing is held on the next available court date, as these hearings usually are held one day per week in each county.) The statute also provides that if the court determines "that the patient is mentally ill and in need of retention for involuntary care and treatment," the court will issue an order authorizing the involuntary retention of the patient for up to sixty days. Article 9 defines "in need of involuntary care and treatment" as meaning "that a person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." In addition, courts have consistently held that for such a commitment to satisfy constitutional due process requirements, the patient must present a "real and present threat of substantial harm to himself or others."[5]

The Involuntary Admission

A psychiatric hospital, pursuant to Article 9, may admit and retain as an involuntary patient "any person alleged to be mentally ill and in need of involuntary care and treatment upon the certificates of two examining physicians, accompanied by an application for the admission of such person." An admission under this section is often referred to as a "2 PC" admission because of the requirement for two physician certificates. This should not be confused with the "emergency admission," discussed in detail below. The statute explains that the physician's examinations must be made within ten days prior to admission, they may be conducted jointly, but each physician must execute a separate certificate. Each certificate must include the facts and circumstances forming the basis of the physician's judgment that the person is mentally ill and that his or her condition is such that he or she needs involuntary care and treatment in a psychiatric hospital. The accompanying application, which must be signed within ten days prior to the admission, may be made by, among others, someone who lives with the mentally ill person, a close relative, the director of a hospital in which the patient is hospitalized, or a "qualified psychiatrist who is either supervising the treatment of or treating such person for a mental illness in a facility licensed or operated by the office of mental health."

The hospital may retain a patient for up to sixty days from the date of admission or conversion (from voluntary status) to involuntary status. At any point within that period, the hospital has a duty to convert the patient to voluntary status if the patient is suitable and willing to apply for such status. Further, within the sixty-day retention period, the patient, or someone on his/her behalf, may request a court hearing to determine the necessity of continued involuntary retention. The hospital must forward notice of this request to the court "forthwith," and the hearing must be set for a date within five days of the court's receipt of the notice. The result of the hearing can be either the patient's release or his or her continued retention in the hospital.

If the hospital determines that an involuntary patient is in need of further retention beyond the initial sixty-day period, and the patient is unwilling to remain in the hospital as a voluntary patient, the hospital must apply for a court order, pursuant to Article 9, authorizing continued retention for a period up to six months. The hospital's application must be made no later than sixty days from the date of the initial involuntary admission or conversion, and the hospital must give written notice of its application to the patient and to MHLS. The notice must state that a hearing may be requested within five days (excluding Sundays or holidays), and that if a hearing is not requested within that period, the court may issue an order authorizing continued retention without a hearing. A subsequent court order authorizing continued retention may be for a period of not more than one year. After that, each subsequent court order may be for a period of up to two years.

The Emergency Admission

Article 9 authorizes emergency admissions to a psychiatric hospital for a period not to exceed fifteen days if a staff physician—usually an emergency room physician—examines the patient and finds that he or she has "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others," provided the staff physician's finding is confirmed within forty-eight hours by another examining physician, who must be a member of the hospital's psychiatric staff. According to the statute, "likely to result in serious harm" means that there is a "substantial risk of physical harm to himself . . . [or] other persons" as manifested by "threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself," or "homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm." If the patient does not agree to be retained as a voluntary patient, he or she may be retained beyond the initial fifteen-day period only by continuing the admission as an involuntary patient pursuant to the provisions of Article 9 discussed above.

Assisted Outpatient Treatment (Kendra's Law)

The following will address the question of who qualifies for services under the Assisted Outpatient Treatment statute, how a Court application is initiated and who is a proper person to be a petitioner. Furthermore, this article will review the services that are typically provided to an individual who is subject to an Assisted Outpatient Treatment Order.

To successfully obtain an Assisted Outpatient Treatment Order, there must be a proper applicant (the Petitioner) and subject (the Person in Need). There must also be a plan of treatment approved by the county or local Assisted Outpatient Treatment Program. The county or local program is responsible for ensuring the quality of benefits offered, case management services and other administrative duties.

New York's Mental Hygiene Law (MHL) § 9.60 is the statutory framework for the Assisted Outpatient

Treatment program. The Mental Hygiene Law delineates the criteria for a person to be required to comply with an Assisted Outpatient Treatment Order as follows: The subject must be eighteen years of age or older and suffering from a mental illness, he or she must be unlikely to survive safely in the community without supervision, based on a clinical determination and a history of lack of compliance with treatment for mental illness that has: (i) at least twice within the last thirty-six months been a significant factor in necessitating hospitalization in a hospital, or receipt of services in a forensic or other mental health unit of a correctional facility or a local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition or; (ii) resulted in one or more acts of serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition. In addition, the subject, as a result of his or her mental illness, is unlikely to voluntarily participate in the recommended treatment provided for in the treatment plan and in view of the patient's treatment history and current behavior, the patient is in need of Assisted Outpatient Treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and the person will likely benefit from Assisted Outpatient Treatment.

MHL § 9.60 also lists the individuals who can petition for a court order for Assisted Outpatient Treatment as follows: (i) any person eighteen years of age or older with whom the subject of the petition resides; or (ii) the parent, spouse, sibling eighteen years of age or older, or child eighteen years of age or older of the subject of the petition; or (iii) the director of a hospital in which the subject of the petition is hospitalized; or (iv) the director of any public or charitable organization, agency or home providing mental health services to the subject of the petition in whose institution the subject of the petition resides; or (v) a qualified psychiatrist who is either supervising the treatment of or treating the subject of the petition for a mental illness; or (vi) the director of community services, or his or her designee, or the social services official, as defined in the Social Services Law, of the city or county in which the subject of the petition is present or reasonably believed to be present; or (vii) a parole officer or probation officer assigned to supervise the subject of the petition.

Like most matters under the Mental Hygiene Law, issues relating to Assisted Outpatient Treatment, both legal and clinical, are complex and often provide a significant source of stress to family and loved ones. The assistance of an attorney may provide navigation through a complex legal system and also a buffer between the person in need and the family seeking help for him or her. Once a petition is filed, there will be a court hearing to judicially determine whether or not the person in need should be legally bound to follow an Assisted Outpatient Treatment Order.

Once an Assisted Outpatient Treatment Order is granted by a court, those services provided for in the proposed Treatment Plan are put in place with a treatment plan that is approved by the county's Assisted Outpatient Treatment Program. The individual, as previously discussed, is assigned an Intensive Case Manager (ICM) or an ACT team (Assertive Community Treatment team) (required by the statute) that provides comprehensive assistance and supervision of all facets of treatment and daily living. Additional services may include alcohol and drug counseling and treatment, psychiatric treatment, therapy, medication management and distribution; and supportive housing is also provided, if necessary.

The Mental Health Warrant

There is nothing more difficult than watching loved ones discontinue treatment, disconnect from those who support him or her and spiral into the throes of their illness. It becomes even more difficult when community-based mental health evaluators and the police are unresponsive to pleas to bring a loved one into a hospital for observation and treatment. Family and other individuals who care for the mentally ill in the community should not have to wait until their loved one hurts him or herself or others, or is arrested, before he or she can be evaluated and treated in a hospital. There is an alternative.

Although it has been "on the books" for more than a decade, MHL § 9.43, more commonly known as the Mental Health Warrant, is an underutilized but useful tool to connect an individual with a mental illness (the alleged person in need), to the health care provider, before being placed in the criminal justice system or doing anything that is truly harmful. The Mental Health Warrant is an order for immediate evaluation in an Emergency Room not to exceed 72 hours, authorized by a Justice of the Supreme Court of the State of New York, in the county in which the alleged person in need resides. Family, friends and other concerned individuals, such as case managers, have the right to make an application to the Court for a Mental Health Warrant. The applicant will need to submit a verified statement (a statement where the contents are sworn to be true to

the best of the applicant's knowledge), that supports a contention that, "[the] person is apparently mentally ill and is conducting himself or herself in a manner which in a person who is not mentally ill would be deemed disorderly conduct or which is likely to result in serious harm to himself or herself."[6] This is the legal standard by which the Judge will determine whether or not the alleged person in need will be remanded to a hospital for evaluation.

The Mental Health Warrant process is completed in two parts. First, a hearing is held or papers are submitted, in which the applicant will testify or swear to facts from which the Court will determine whether or not the alleged person in need should be taken into custody and brought before the Judge. Second, a hearing is held to determine whether or not the alleged person in need should be referred to a hospital. It is best to present to the Court in both proceedings as much information as possible which supports the contention that the alleged person in need should be immediately hospitalized for evaluation.

At the first proceeding, the Judge will scrutinize the applicant's verified statement and any other evidence very closely because these proceedings deal with the potential deprivation of an individual's liberty. Prior hospital and medication records, out-patient care records, police reports, sworn narratives or actual live testimony by family and friends regarding the individual's recent behavior in the community are all useful tools in proving to a Judge that the alleged person in need should be immediately referred/remanded to a hospital. If the Judge is satisfied by the proof presented, the Judge will issue an Order authorizing the local authorities (depending on the county, either the sheriff or the local police department), to take the person in need into custody in order to produce that person before the Judge.

The second proceeding will begin as soon as the alleged person in need is brought to the Court. The Judge will conduct a more formal inquiry into the evidence than in the first proceeding. The alleged person in need has the right to testify and to be represented by counsel. The applicant and any other witnesses will be given an opportunity to testify and present evidence. Once the determination is made that the individual meets the above-referenced legal standard, the Judge will sign a Court order authorizing the person's remand to a Psychiatric Emergency Room in a local hospital that is designated by the county for that purpose, for an observation and treatment period not to exceed 72 hours.

It is important to note that the Mental Health Warrant, although a state law, is frequently utilized by courts in some counties, while not used at all in other counties. The reason for this is unclear. The fact remains that this is provided for by state law and must be, at a minimum, heard in any New York Court. Families, friends and advocates for the mentally ill should remain strong and persevere in their local county, seek legal counsel, educate the Judge on the applicable law and provide enough proof to convince a Judge that the alleged person in need should be referred to a hospital for observation and treatment.

Once the Mental Health Warrant is granted and the person in need is brought to a local hospital, what happens next? Advocacy. Psychiatric Emergency Room evaluators often fall prey to the same problem as the local police and Mobile Crisis Teams—insufficient information. Family, friends and other concerned individuals should accompany their loved one to the Emergency Room bringing with them as much information as possible regarding his or her psychiatric history, medication/medical history and current behavior and remain available to the treatment team as a source for future information, particularly if more than 72 hours of care and treatment are required.

Guardianship

New York Mental Hygiene Law's Article 81 is the legal mechanism through which a family member, or other person designated by the Court, can be given decision-making authority (Guardianship) over an "Incapacitated Person."

> **Incapacity** is defined in three parts: 1) The Alleged Incapacitated Person ("AIP"), has certain functional limitations; 2) The AIP lacks an understanding and appreciation of the nature and consequences of his/her functional limitations; and, 3) There is a likelihood that the person will suffer harm because of the person's functional limitations and inability to adequately understand and appreciate the nature and consequences of such functional limitations.

It should be noted that the incapacity must be enduring. The incapacity cannot be a brief psychiatric decompensation that will be remedied in an acute psychiatric hospital or by a community intervention. Rather, as a result of chronic illness, the AIP, even at his or her baseline, remains incapacitated or with "functional inability" to do certain things.

It is important to note that incapacity need not be total. In fact, the law encourages the greatest amount of participation in decision-making by the Incapacitated Person consistent with their functional limitations. Moreover, the Judge hearing the case is obligated to narrowly tailor the powers granted to the Guardian after considering the Incapacitated Person's functional limitations. After a judicial determination of incapacity, a Guardian may be given powers relating to the Incapacitated Person's personal needs, property management or both. While Guardianship under MHL's Article 81 provides for a broad array of substitute decision-making options, there are some limitations.

Certain aspects of an Incapacitated Person's care may not be delegated to a Guardian. While we have limited appellate guidance and no definitive rulings from the Court of Appeals, historical practice and lower court rulings show us that a Guardian is limited in the following ways: A Guardian may not consent to the voluntary or involuntary admission of an Incapacitated Person to a psychiatric facility.[7] Additionally, a Guardian may not consent to the administration of psychiatric medications at any time, and/or consent to an involuntary medical procedure when the Incapacitated Person is in a psychiatric facility.[8] Previously executed advanced directives, such as a health care proxy, living-will or power-of-attorney, may only be terminated by the Incapacitated Person or a Judge's order in the Guardianship proceeding.[9]

During the course of an acute psychiatric decompensation a Guardian's powers are essentially restricted, giving way to those areas of relief authorized by Article 9 or Article 81 of the Mental Hygiene Law. The Guardian's authority over general medical treatment and financial/property decisions will remain intact.

Conclusion

Providing access to quality care is not an impossible task. However, as Michael Hogan observed, our mental health system is a "patchwork relic" which provides significant challenges to establishing a comprehensive plan of care. With the assistance of knowledgeable legal professionals, it is possible to coordinate services, health care professionals and the legal system to achieve a positive outcome for those who experience a decompensation of their mental health.

Endnotes

1. *Substance Abuse and Mental Health in New York, 2001,* Council, Carol l.; Shi, Weihua; Hourani, Laurel L.; (Department of Health and Human Services–May 2005).

   Serious Mental Illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder that met criteria in DSM-IV and that resulted in functional impairment and substantially interfered with or limited one or more major life activities at some time during the past year.

   Id. p. 3.
2. Source: New York City Department of Health and Mental Hygiene.
3. *Id.*
4. *Id.*
5. The phrase "real and present threat of substantial harm to himself or others" is the most frequently litigated issue in a hearing to determine whether or not a patient should be released from a hospital. Because of the volume and breadth of the cases and commentary on this issue it will not be addressed at length in this article.
6. MHL § 9.43. It should be noted that, depending on the county, more legal documentation may be required. For instance, Suffolk County requires an Order to Show Cause with supporting papers while Kings County will accept an application by a concerned individual alone. It will prove helpful to seek legal counsel or the assistance of the clerk of the court to determine what legal documentation is required in your county.
7. MHL § 81.22(b)(1); *In re Gordon*, 619 N.Y.S.2d 235 (Supreme Court, Rockland County 1994).
8. MHL § 81.22(b)(1); *In re Farbstein,* 619 N.Y.S.2d 239 (Supreme Court, New York County 1994).
9. MHL § 81.22(b)(2), 81.29(d); otherwise these advance directives will "survive" the Guardianship and remain in effect.

Carolyn Reinach Wolf is a partner in the firm of Reinach Wolf, Rothman & Stern which concentrates in the area of Mental Health/Health Care Law, providing legal representation and consultation to hospitals, skilled nursing facilities, outpatient centers, families, individuals, mental health practitioners and attorneys. She is the firm's founding partner and has lectured, counseled, provided advice and written extensively in these areas to mental health and health care medical and legal professionals.

Douglas Stern is a partner in the firm of Reinach Wolf, Rothman & Stern which concentrates in the area of Mental Health/Health Care Law, providing legal representation and consultation to hospitals, skilled nursing facilities, out-patient centers, families, individuals, mental health practitioners and attorneys. He holds a J.D. from New York Law School and a B.A. from Hofstra University. He was previously a Principal Attorney with the Mental Hygiene Legal Service, an Adjunct Professor of Law at St. John's University School of Law, and has also lectured and written extensively on issues relating to psychiatry and the law, trial advocacy and select elder law issues.

Consent and Confidentiality in the Mental Health Treatment of Minors

By Pamela Tindall O'Brien

Introduction

Health care law relating to persons under the age of eighteen can be confusing and complicated, at least in part because of the number of different parties and interests that may be involved. Issues concerning consent to treatment and access to clinical records, never easy subjects, can become far more complicated when minors are involved. The child's rights must always be balanced with the parent(s) or guardian(s) rights, in reviewing issues concerning consent to treatment, inpatient admissions, and access to the child's clinical records. This confusion may be even more pronounced when it comes to issues regarding care and treatment for mental health issues.

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Some of the confusion that arises in the course of determining issues such as who should consent to treatment arises not from the law, but from the complicated nature of today's family life. The days of Ward and June Cleaver are long gone. Children in today's world, whether in need of mental health services or not, are far more likely to have parents who are divorced, parents who were never married, be raised by grandparents, stepparents or other family members, or be in foster care, than children just thirty years ago. In addition, even in today's more enlightened world, psychiatric hospitalization carries a stigma that hospitalization for medical care does not, an issue which can greatly raise the level of concern for some parents if a child is recommended for inpatient hospitalization. Given this complicated arena, the question arises—from whom should a provider obtain consent to treatment?

Who Can Consent to a Voluntary Admission?

As background, there are three mechanisms set forth in the Mental Hygiene Law ("MHL") under which a person can be hospitalized: informal admissions, voluntary admissions, and involuntary admissions. Informal admissions allow a person to request admission to a psychiatric hospital without making a formal written application. MHL § 9.15. Such admissions are seldom if ever used, and therefore will not be discussed in this article. Voluntary admissions are as named—the person has voluntarily agreed to an admission in order to receive inpatient mental health care. MHL § 9.13. Involuntary admissions are a mechanism by which a person found to be "a danger to self or others" is involuntarily retained for the purpose of receiving care and treatment. MHL §§ 9.27, 9.31, 9.33, 9.37, 9.39, 9.40, 9.41, 9.43 and 9.45.

The vast majority of minor admissions are done as voluntary admissions, but that does not mean that all minors voluntarily admitted have agreed to receive treatment. A minor need not consent for an admission to be " voluntary"; consent of the parent is considered sufficient for admission of a child to a facility on a voluntary basis. MHL § 9.13(a) provides that:

> The director of any hospital may receive as a voluntary patient any suitable person in need of care and treatment, who voluntarily makes written application therefor. If the person is under sixteen years of age, the person may be received as a voluntary patient only on the application of the parent, legal guardian, or next-of-kin[1] of such person. . . If the person is over sixteen and under eighteen years of age, the director may, in his discretion, admit such person either as a voluntary patient on his own application or on the application of the person's parent, legal guardian, next-of-kin. . . .

First is the issue of parental consent. The best case scenario, of course, is one in which the child has one or more custodial parents who consent to the admission, or the custodial parent and non-custodial parent agree to the admission and the child acquiesces (or at least does not object). However, there are many other instances where the situation is not as clear cut, for example, where one parent does not agree with the

other parent that their child requires psychiatric hospitalization. And there are many children whose parents are unmarried; or have been raised by grandparents or stepparents or other family members who have never sought or obtained legal custody, yet the children have been raised by these adults for most or all of their lives. Add to that mix the issue of adolescents who may not agree with family decision makers, and it can be seen why this area is one of continued confusion. In such circumstances, to whom does a health care provider turn for consent to mental health care?

When parents who do not agree are divorced, first look to see whether there is a divorce decree which states which parent has the legal authority to consent to medical treatment. However, in many cases the divorce decree provides for "joint custody," but does not explicitly state which parent has the right to consent to treatment; or both parties are given the legal authority to consent to treatment, but there is no dispute resolution provision should the parties disagree on the course of treatment. This can put a mental health care provider in the role of referee between warring family members as to whether and what type of care should be provided.

In New York, if parents share custody, and the divorce decree either does not explicitly provide the ability to consent to treatment to one parent, or does not have a mediation mechanism if there is a disagreement regarding medical care, the health care provider can legitimately accept the consent of the parent who agrees with the recommendation of the treating professional, since Domestic Relations Law § 81 provides that parents have equal rights to consent to treatment on behalf of their children. As long as both parents have the ability to consent to treatment, it can be argued that a health care provider can and should be immune from potential liability if it accepts a legal and legitimate parental consent which comports with a recommended course of treatment. It is not the responsibility of health care providers to act as divorce mediators.

When the parents are unmarried, or married and are separated without a written separation agreement, in practice health care providers generally defer to the custodial parent. If the custodial parent does not agree to an inpatient admission and the treating provider believes that an admission is essential for a child's well-being, there are two options.[2] First, if the child is over the age of sixteen, the director of a hospital "may, in his discretion, admit such person either as a voluntary patient on his own application. . . ." (MHL § 9.13(a)). Second, if, in the director's opinion, based on psychiatric evaluations, the child does not have the capacity to consent to voluntary admission, or the child is under the age of sixteen and does not have the legal ability to consent to an admission, the custodial parent could be informed that if he or she does not consent to treatment, the facility may be obligated to call the Child Abuse Hotline and report that there appears to be a case of potential abuse or neglect, as a result of necessary medical treatment being withheld from a child.[3] This is, of course, a last resort, since so doing will alienate the parent(s)/guardian(s) and may greatly complicate treatment.

Obviously the first recommendation is always to work with the parent(s)/guardian(s) to obtain consent by providing full and complete information regarding the course of recommended treatment, and the reasons therefor. A court order can be pursued authorizing treatment, but that is more time consuming and may be unnecessary if the parent or guardian is informed of the provider's responsibility to contact the Child Abuse Hotline regarding medical neglect. Once a referral has been made to the Department of Social Services (DSS), it is up to DSS to act in a *parens patriae* capacity in regard to the minor child, and if the agency does not agree with the facility's assessment as to the need for treatment, the facility really has no other options. The facility has fulfilled its obligation to attempt to provide the needed care.

This obviously raises the issue as to who can consent to treatment if a child is in foster care. The answer to that is dependent on how and why the child entered the foster care system. An important fact that must always be recognized is that surrender or termination of one parent's parental rights does not diminish or terminate the other parent's parental rights in any respect. There are two ways a child can enter the foster care system—voluntarily or involuntarily.

There are two ways a child can enter the foster care system voluntarily:

1) A parent can voluntarily surrender his or her child to an authorized agency. In that instance, DSS is the child's guardian and can consent to medical treatment.

2) A parent can temporarily place his or her child with DSS. In that instance only care and custody is transferred. The parent(s) delegate to DSS the power to consent to "routine medical treatment." Not surprisingly, psychiatric hospitalization and/or the administration of psychotropic medication is not considered to be "routine medical treatment." However, the delegation instrument

can be drafted to allow DSS the right to consent to admission to an inpatient psychiatric setting, and/or the right to consent to psychotropic medication. Unless the delegation instrument contains such consent, the parents must be contacted to obtain consent for such an admission or administration of psychotropic medications.

There are two ways a child can enter the DSS foster care system involuntarily:

1) When the Family Court finds that a child is a "Person in Need of Supervision," or a "Juvenile Delinquent," the child enters the DSS system. However, DSS has no specific statutory authority to consent to treatment for medical care for the child, so again what is called a "delegation instrument" comes into play. The parent(s) delegate to DSS the power to consent to "routine medical treatment." Again, psychiatric hospitalization and/or the administration of psychotropic medication is not considered to be "routine medical care" and is therefore not covered under the delegation instrument. The delegation instrument can be drafted to allow DSS the right to consent to admission and the administration of psychotropic medication, but typically it does not.

2) If the parent(s) have been found guilty of abuse or neglect, or the child has been placed in protective custody, under Social Services Law § 383(b), DSS has specific statutory authority to consent to all medical treatment, including psychiatric hospitalization and/or the administration of psychotropic medication.

Can a stepparent give consent to inpatient admission? Temporary written authorization to consent to treatment on behalf of the child can be given by the parent to the stepparent or any other family member. General Obligations Law ("GOL") § 5-1551(1) provides as follows:

> A parent of a minor or incapacitated person may designate another person as a person in parental relation to such minor or incapacitated person . . . for a period not exceeding six months provided that there is no prior order of any court in any jurisdiction currently in effect that would prohibit such parent from himself or herself exercising the same or similar authority, and provided further, that, in the case where a court has ordered that both parents must agree on education or health decisions regarding the child, a designation pursuant to this subdivision shall not be valid unless both parents have consented thereto. Such designation shall be in the form prescribed by section 5-1552 of this title . . .

GOL § 5-1552, entitled "Form of Designation," provides that the designation shall be in writing and notarized, and shall include the name of the parent, the name of the designee, the name of each minor or incapacitated person with respect to whom such designation is made, the parent's signature, and the date of such signature. A designation which is intended to be valid for more than thirty days must also include an address and telephone number where the parent can be reached, an address and telephone number where the designee can be reached, the date of birth of each minor or incapacitated person with respect to whom such designation is made, the date or contingent event on which the designation commences, the written consent of the designee to such designation, and a statement that there is no prior order of any court in any jurisdiction currently in effect prohibiting such parent from making the designation. If the designation does not specify a time certain for the delegation, and does not meet the requirements of a designation for more than six months, it is considered to be valid until either the earlier of revocation or thirty days from the date of signature. If it does meet the requirements of a designation for more than six months, it is valid for six months from the date of commencement specified therein.

A designation can specify the treatment, diagnosis or activities for which consent is authorized; any treatment, diagnosis or activity for which consent is not authorized; or any other limitation on the duties and responsibilities conveyed by the designation. A parent may revoke a designation by notifying, either orally or in writing, the designee or a school, health care provider, or health plan to which the designation has been presented, or by any other act evidencing a specific intent to revoke the designation. A designation may also be revoked by the execution of a subsequent designation. Revocation by one parent authorized to execute a designation shall be deemed effective and complete revocation of a designation. Either the designee or the parent should immediately notify the school, health care provider or health plan that has received a copy of the designation when it has been revoked. It is important to note that a designee's decision can always be superseded by a contravening decision of a parent, but

it is also important for health care providers to know that a person or entity which acts based upon the consent of a designee "reasonably and in the good faith belief that the parent has in fact authorized the designee to provide such consent," may not be deemed to have acted negligently, unreasonably or improperly in accepting the designation and acting upon such consent. GOL § 5-1555(6).

If the parent is unavailable and the stepparent does not have a delegation instrument, the health care provider must determine if the stepparent might be considered to be "next of kin" since the MHL allows "next of kin" to consent to a voluntary admission. MHL § 9.13. Factors to be considered are: whether the parent can in fact be reached or will be available in the near future; how long the stepparent has been involved in the child's life; and whether there are any other family members who have taken a greater role in the child's upbringing. If the stepparent is clearly the person most involved in the child's life, accepting a consent from that individual as "next of kin" is legally defensible.

Next comes the issue of when a minor can consent to treatment, and the concomitant issue as to when a minor can refuse treatment. Under common law, minors are generally not considered to have the requisite capacity to consent to treatment on their own behalf. Under both the Mental Hygiene Law and the Public Health Law the only adolescents who are treated as adults are those who have been emancipated,[4] married, or the parent of a child. MHL § 33.21(a)(1), PHL § 2504. If the adolescent meets one of these criteria, he or she is treated as an adult, has control over his or her medical decision-making and the parent(s) or guardians are not legally authorized to make medical decisions.

There are certain exceptions to the common-law rule regarding the legal incapacity of minors to consent to treatment, particularly in the area of reproductive issues. PHL § 2305(2), 2782; *Carey v. Population Services International*, 431 U.S. 678 (1977). MHL § 9.13 contains one of the statutory exceptions to the general common law rule. MHL § 9.13 provides that the director of a psychiatric hospital or psychiatric unit of a general hospital can admit an adolescent over age sixteen and under the age of eighteen as a voluntary patient on his or her own application. Such minors are frequently referred to as "mature minors."

The important caveat to this provision is that the adolescent must be able to "knowingly and voluntarily" consent to the admission. MHL § 9.13. An adolescent who is in an acute psychotic state, for example, may not have the requisite mental capacity to consent to a voluntary hospitalization.[5] Therefore, the first issue that must be resolved by the hospital director in making a decision as to whether a particular adolescent over sixteen can voluntarily be admitted on his or her own consent is the issue of capacity. Only if the child has capacity can he or she be voluntarily admitted on his or her own application. 14 N.Y.C.R.R. § 527.8 defines capacity as "the patient's ability to factually and rationally understand and appreciate the nature and consequences of proposed treatment, including the benefits, risks and alternatives to the proposed treatment, and to thereby make a reasoned decision about undergoing the proposed treatment." Assuming that the minor has capacity, he or she can sign for a voluntary admission. Generally, if a parent/guardian is willing and available to consent to admission, it is the parent's consent which is sought first, not the child's.

The question then arises as to whether a mature minor who has consented to an admission can "sign" out of that same admission, **if** his or her parents want the minor to remain in inpatient treatment. There is no statute or case law directly on point. In the only case to date that has poised the issue, *In re Long Island Jewish Medical Center*, 147 Misc. 2d 724 (Supreme Court, Queens County 1990), the judge found the minor not to have capacity to make the decision and therefore skirted the issue. The Court did state as dicta that the Legislature should act to clear up ambiguities in the law concerning whether a mature minor who can consent to treatment can also refuse treatment. However, to date the Legislature has not done so.

A review of the principles enumerated in other case law regarding "mature minors" could lead to the conclusion that even for an adolescent over sixteen, who has capacity, if the parent wants the child to be admitted, the health care provider is legally protected if the child is admitted. It can be argued that the fact that the law allows a mature minor to sign for voluntary admission does not terminate parental rights such that the child becomes the sole or final decision-maker regarding his or her mental health care.

There are ambiguities in the law which must be acknowledged. MHL § 9.13(b) provides that:

> In the case of a patient under eighteen years of age . . . notice requesting release of the patient may be given by the patient, by the person who made application for his admission, by a person of equal or closer relationship, or by the mental hygiene legal service. If such notice be given by any other per-

> son, the director may in his discretion refuse to discharge the patient and in the event of such refusal, such other person or the mental hygiene legal service may apply to the supreme court or to a county court for the release of the patient.

In addition, the MHL provides that, "In the case of a patient under eighteen years of age . . . notice requesting release of the patient may be given by the patient, by the person who made application for his admission, by a person of equal or closer relationship, or by the mental hygiene legal service."

It could be argued that the law would not allow a mature minor to file a notice of release if the minor did not have the legal right to exercise the right to contest the hospitalization. However, the fact that a mature minor can give a notice of release when he or she has signed in is not in dispute. What is in dispute is whether the director must honor the request for release if the minor's parent(s)/guardian(s) dispute(s) the release. To argue that a minor can sign out of inpatient care if the parent disagrees disregards a long line of cases regarding parental right to consent to treatment. *See Parham v. J.R.*, 442 U.S. 584 (1979); *Alfonso v. Fernandez*, 195 A.D.2d 46 (2d Dep't 1993). As stated by the court in the *Long Island Jewish Medical Center*, *supra*, the right to consent to treatment does not necessarily imply the right to refuse treatment. It can be argued that the parental right to consent on the minor's behalf is not extinguished by the mature minor statute, but merely allows the mature minor to consent on his or her own behalf. Since the decision as to whether the child can be admitted as a mature minor rests within the discretion of the director of the facility, it does not appear that the mature minor has an absolute right to consent to treatment on his or her own behalf, but rather that in some instances such admissions will be accepted. If, however, the child seeks a discharge and the parents(s)/guardian(s) wish for the child to remain in treatment, both the child and the Mental Hygiene Legal Services (MHLS) should be given a written notice per MHL § 9.13, which provides:

> In the case of a patient under eighteen years of age, a notice requesting release of the patient may be given by the patient, by the person who made application for his admission, by a person of equal or closer relationship, or by the mental hygiene legal service.

What if an adolescent under sixteen objects to hospitalization? Generally under the law children under sixteen are not considered to have the requisite capacity to give or withhold consent to treatment. (The major exception relates to sexual reproduction and contraception issues.) Again, one must look to general legal principles. The court in *In re Thomas B.*, 152 Misc. 2d 96, (Family Court, Cattaraugus County 1991) stated that:

> Under Public Health Law § 2504(1) '[a]ny person who is eighteen years of age or older . . . may give effective consent for medical, dental, health and hospital services for himself or herself.' An implicit corollary of that provision is that a person under 18 years of age may not give effective consent for such services. If a person under 18 years of age may not give effective consent, it follows logically that such a person may not effectively withhold consent, either. Generally, an infant 'is universally considered to be lacking in judgment, since his normal condition is that of incompetency' (66 NY Jur 2d, Infants and Other Persons Under Legal Disability, § 3).

Since adolescents under the age of sixteen do not have the legal ability to apply for voluntary admission under MHL § 9.13, given the court's statement of the law in the above-named case, it is doubtful that they have the legal ability to sign themselves out. Therefore, the parent or guardian's desire that the child be retained by the facility should be sufficient if an independent entity, a facility psychiatrist, agrees that the child continues to need hospitalization.

There are children's advocacy groups that would argue that children can bring an application for release, regardless of age, due to an ambiguity in the MHL. MHL § 9.09 provides:

> When any person under the age of eighteen years is admitted to or is converted from one admission status to another in any hospital, written notice of such admission or conversion shall be given to the mental hygiene legal service within three days thereof and such notice shall specify the age of and admission procedure applicable to such person.

MHLS has argued that since the statute provides that they receive notice of all minor admissions, it must be for the purpose of allowing them to challenge the child's admission status. MHLS also has argued that the fact that MHL § 9.09 requires MHLS receive notice regardless of the child's age, that the law does not differentiate minors over age sixteen from those under sixteen, shows legislative intent that all children be able to challenge their admission status, regardless of age.

The law is certainly not consistent on this point, and there is no legislative history to assist in determining legislative intent. However, given the explicit provision in MHL § 9.13 regarding mature minors, it must be assumed that the fact that MHLS is required to receive notice does not give the child the ability to challenge his or her admission status. In addition, MHL § 29.15 provides that a minor voluntary patient under the age of sixteen may be conditionally released only after consultation with the parent, legal guardian, or next of kin of such patient; but a minor voluntary patient over sixteen and under eighteen may be conditionally released with his consent **or** the consent of his or her parent, legal guardian, or next of kin. This appears to support the argument that children under sixteen are bound by their parent(s)' decisions concerning treatment. Although a hospital need not release a child under sixteen, or even follow the involuntary commitment procedures, MHL § 9.13 does provide that, "In the case of a patient under eighteen years of age . . . notice requesting release of the patient may be given by the patient, by the person who made application for his admission, by a person of equal or closer relationship, or by the mental hygiene legal service. If such notice be given by any other person, the director may in his discretion refuse to discharge the patient and in the event of such refusal, such other person or the mental hygiene legal service may apply to the supreme court or to a county court for the release of the patient." It should be noted that as with MHL § 9.90, the statute does not differentiate between children who are over the age of sixteen from those who are under the age of sixteen. Notice should therefore be given, but again, the child does not appear to gain legal rights from the fact that MHLS receives notice.

There has been only one case on point dealing with children under age sixteen, and in that case the Court found that the guardian's consent overruled the child's request for release. The case, *Mental Hygiene Legal Services o/b/o Camile Hendrichs v. Dennis Dubey, Sagamore Children's Psychiatric Center*, (Supreme Court, Suffolk County 2005) (appeal pending) appears to be a case of first impression. The MHLS brought a Writ of Habeas Corpus on behalf of the minor child, age 14. The minor had been voluntarily admitted to Sagamore by the local Department of Social Services. She requested release. The court denied the petition, stating that,

> It is quite clear that an infant under 16 years of age cannot be admitted as a voluntary patient. Accordingly, the rights of a 'voluntary patient' under § 9.13 of the MHL do not attach to an infant under 16 years of age admitted upon application of a parent, guardian, or person having legal custody. It follows that if an infant under 16 years of age cannot attain the status of voluntary patient to enter a hospital, he or she cannot exit a hospital by applying a procedural safeguard adopted for adults or 'mature minors. . . .'"

The most important factor in such cases, regardless of the child's age, would seem to be the recommendation of the treating provider. It would be far more likely that a court would give deference to the parent(s) or guardian(s) wishes if the course of treatment is supported by the physician's testimony that the child needs hospitalization.

The leading United States Supreme Court case on point (indeed, the only Supreme Court case on point) is *Parham v. J.R.*, 442 U.S. 584 (1979). The Supreme Court found that voluntary hospitalizations of minors, wherein minors are admitted under a parent or guardian's consent, under a statutory scheme similar to New York State's, met due process standards. In making that determination, the court was persuaded that parents are in large part guided by the best interests of their children. The Court also found that an adversarial proceeding, such as is the case in an involuntary commitment proceeding, is both undesirable and not constitutionally mandated. The Court was concerned that an adversarial proceeding would pit parent against child, an outcome which could not but be to the detriment of the child's mental health. As stated by the Court in that case:

> The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children. *Citing* 1 W.

> Blackstone, Commentaries *447; 2 J. Kent, Commentaries on American Law *190.

It was the opinion of the Court that as long as there was a neutral fact finder who found that the child meets the statutory standard for commitment, the child had been afforded sufficient due process. As stated by the Court in *Parham*:

> In defining the respective rights and prerogatives of the child and parent in the voluntary commitment setting, we conclude that our precedents permit the parents to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse, and that the traditional presumption that the parents act in the best interests of their child should apply. We also conclude, however, that the child's rights and the nature of the commitment decision are such that parents cannot always have absolute and unreviewable discretion to decide whether to have a child institutionalized. They, of course, retain plenary authority to seek such care for their children, *subject to a physician's independent examination and medical judgment*. (Emphasis added.)

The New York State Voluntary Commitment statute appears to meets that test. However, it should be noted that if a minor under the age of sixteen, or a minor over the age of sixteen who has not signed him or herself into a facility, notifies the facility director in writing that he or she does not wish to remain at the facility, the law would appear to require the facility to provide MHLS with a copy of the notice within three days of the receipt thereof.

Consent to Psychotropic Medication

The primary reason most minors are admitted to inpatient settings is to stabilize their behavior, and finding the correct dosage of modern psychotropic medication is an important part of the service received in hospital settings. Obtaining consent to psychotropic medications for a minor residing in an inpatient setting is a critical element for effective treatment, and has its own statutory scheme.[6] MHL § 33.21(b), the controlling statute, states:

> In providing . . . psychotropic medications to a minor residing in a hospital, ***the important role of the parents or guardians shall be recognized.*** As clinically appropriate, steps shall be taken to actively involve the parents or guardians, and the consent of such persons shall be required for such treatment in such non-emergency situations, except as provided in subdivisions (c), (d) and (e) of this section or section two thousand five hundred four of the public health law.[7] (Emphasis added.)

MHL § 33.21(e) provides that:

> Subject to the regulations of the commissioner of mental health governing the patient's right to object to treatment, subdivision (b) of this section and paragraph two of this subdivision, *the consent of a parent or guardian or the authorization of a court shall be required for the non-emergency administration of psychotropic medications to a minor residing in a hospital.* (Emphasis added.)

Although MHL § 33.21 emphasizes that the parents or guardian's role should "be recognized," it goes on to provide the circumstances under which that role can be bypassed. Paragraph (e)(2) referenced above provides that a minor ***sixteen years of age or older*** who consents may be administered psychotropic medications without the consent of a parent or guardian or the authorization of a court if:

(i) a parent or guardian is not reasonably available,[8] provided the treating physician determines that (A) the minor has capacity; and (B) such medications are in the minor's best interests; or

(ii) requiring consent of a parent or guardian would have a detrimental effect on the minor, provided the treating physician and a second physician who specializes in psychiatry and is not an employee of the hospital determine that (A) such detrimental effect would occur; (B) the minor has capacity; and (C) such medications are in the minor's best interests; or

(iii) the parent or guardian has refused to give such consent, provided the treating physician and a second physician who specializes in psychiatry and is not an employee of the hospital determine that (A) the minor has capacity; and (B) such medications are in the minor's best interests.

If a provider obtains consent from the minor for the administration of psychotropic medications absent parental consent, pursuant to the above-cited section, the reasons must be fully documented and included in the mature minor's clinical record, and notice must be sent to the parent(s).

As can be seen, MHL § 33.21 sets forth the criteria to evaluate whether a mature minor can consent to psychotropic medication if the parent is unavailable or unwilling to consent—it does not deal with the situation where the parent(s) or guardian have consented and the adolescent has refused treatment. The law is silent on the issue of whether a minor can refuse non-emergency medication if the parent(s) have consented. For discrete general hospital psychiatric units, and free-standing psychiatric hospitals, the OMH regulations provide that a patient who is a minor[9] may be provided treatment over his or her objection if the patient's parent, legal guardian or other legally authorized representative has consented, and the minor does not have the legal authority to consent to the treatment. Therefore, in such situations, a child under eighteen but over sixteen who has not voluntarily admitted himself or herself can be administered psychotropic medications with parental consent. A child under the age of sixteen can also be administered psychotropic medications over objection.

In state-operated hospitals, minors of any age who are admitted can object to the administration of psychotropic medication even if the parent or guardian has consented. In such instance, 14 N.Y.C.R.R. § 527.8(c)(2) sets forth the following procedure which must be followed and documented in the patient's chart:

> Upon the patient's objection to the proposed treatment, an independent review shall be conducted by a physician who specializes in psychiatry and is not an employee of the facility. Such independent reviewer, designated by the clinical director, shall review the patient's clinical record, meet with the patient, and provide a recommendation to the clinical director based on an assessment of: (1) the need for the proposed treatment in light of the patient's current condition, the goals for the treatment, the patient's treatment history, any alternatives to the treatment and the therapeutic implications of treating the patient over his or her objection; and (2) the patient's reasons for objecting to the proposed treatment, his or her ability to understand the factors of the decision, and the treatment staff's responses to the patient's objection. Following the completion of the independent review, the clinical director shall also conduct a review. Based on the clinical director's review and the independent reviewer's recommendation, the clinical director shall determine that the treatment be administered over the patient's objection; or be administered after the delay of a specified period of time to permit efforts to obtain the patient's agreement; or not be administered as not in the patient's best interests.

"In state-operated hospitals, minors of any age who are admitted can object to the administration of psychotropic medication even if the parent or guardian has consented."

The clinical director must provide the patient and his or her parent, legal guardian or other legally authorized representative with a full explanation of the clinical director's determination. If the determination is made to administer non-emergency treatment over the patient's objection, the MHLS shall be notified and the initiation of the treatment shall be delayed at least four calendar days. If, within the four-day period, the MHLS files a legal action on behalf of the patient challenging the clinical director's determination as "arbitrary and capricious," the treatment may be initiated three calendar days thereafter, unless otherwise ordered by the court.

Although the State has made the decision to handle minors objecting to psychotropic medication in this manner, and this procedure is applicable only to State-operated hospitals, other providers which follow similar policies would appear to be in a legally defensible position should a minor attempt a legal challenge regarding the administration of medications in the face of the minor's refusal to consent.

Consent to Outpatient Services

In some respects, the law on consent to outpatient mental health services is similar as to the law on repro-

ductive rights in regard to a minor's ability to consent. The Legislature has apparently determined that in order to advance the goal of minors receiving outpatient mental health care, and cognizant of the fact that minors in need of such treatment may want to keep such treatment confidential from their parents, minors may, in certain prescribed circumstances, obtain outpatient mental health treatment without parental consent. Again, as with the law concerning the administration of psychotropic medications, although the law emphasizes that the parents or guardian's role should "be recognized," it goes on to provide the circumstances under which that role can be circumscribed. Again, MHL § 33.21 is the controlling statute. The law states:

> In providing outpatient mental health services to a minor . . . ***the important role of the parents or guardians shall be recognized***. As clinically appropriate, steps shall be taken to actively involve the parents or guardians, and the consent of such persons shall be required for such treatment in non-emergency situations, except as provided in subdivisions (c), (d) and (e) of this section or section two thousand five hundred four[10] of the public health law. . . . (Emphasis added.)

Subdivision (c) states that a mental health practitioner may provide outpatient mental health services[11] to a minor voluntarily seeking such services without parental or guardian consent **if** the mental health practitioner determines that:

(1) the minor is knowingly and voluntarily seeking such services; and

(2) provision of such services is clinically indicated and necessary to the minor's well-being; and

(3) (i) a parent or guardian is not reasonably available; or

(ii) requiring parental or guardian consent or involvement would have a detrimental effect on the course of outpatient treatment; or

(iii) a parent or guardian has refused to give such consent and a physician determines that treatment is necessary and in the best interests of the minor.

MHL § 33.21(d) provides that a mental health practitioner may provide a minor voluntarily seeking outpatient services an initial interview without parental or guardian consent or involvement, in order to determine whether the criteria of subdivision (c) cited above are present.

It must be noted that the mental health practitioner must fully document the reasons for his or her determination(s) in regard to allowing the minor to consent to outpatient mental health services. The documentation must be included in the minor's clinical record, along with a written statement signed by the minor indicating that he or she is voluntarily seeking services. **As clinically appropriate,** a parent or guardian who has refused to give consent to outpatient treatment must be provided with a notice that the child will nonetheless be provided treatment.

Confidentiality

Practitioners and facilities frequently raise issues concerning the confidentiality of issues concerning a minor. The very strict confidentiality provisions of MHL § 33.13 apply to both minors and adults, and to all clinical records, both inpatient and outpatient. Generally speaking, a child's clinical record is exempt from disclosure to outside entities unless the disclosure meets one of the "exception" criteria contained in MHL § 33.13.[12]

This necessarily raises the issue of whether a minor can access his or her own clinical record, and whether information from a minor's clinical record can be shared with parents. The answer is a qualified "yes." MHL § 33.16 provides that a parent, guardian, or the minor involved in treatment, can request in writing an opportunity for such individual to inspect any clinical record concerning or relating to the examination or treatment of the minor in the possession of the provider. The law does, however, allow the child some say in whether his or her parent or guardian is provided with an opportunity to inspect the clinical record, just as it allows the clinician some say as to whether the child can access his or her record.

A minor over the age of twelve may be notified of any request by a parent or guardian to review the minor's record, and if the minor objects to disclosure, the facility, in consultation with the treating practitioner, may deny the request. MHL § 33.16(c)(2). (It should be noted that the language is permissive, rather than mandatory.) Even if the parent or guardian provided consent for the treatment, the treating practitioner[13] can

nonetheless make a determination that "access to the information requested by such parent or guardian would have a detrimental effect on the practitioner's professional relationship with the infant, or on the care and treatment of the infant or on the infant's relationship with his or her parents or guardians" and deny access to the record or parts thereof. MHL § 33.16(c)(3).

The statutory process for access is replete with clinical determinations that must be made by the treating practitioner before access is granted. Once the provider receives a written request to inspect or copy the clinical record, the facility must notify the treating practitioner of the request, who then reviews the requested information. Unless the treating practitioner determines that the requested review of the clinical record can reasonably be expected to cause substantial and identifiable harm to the patient or client or others which would outweigh the right to access the record, review of such record shall be permitted or copies provided. If the treating practitioner determines that the requested review of all or part of the clinical record **could** have such a detrimental effect, the facility may allow access to all or a part of the record or a prepared summary. In determining whether substantial and identifiable harm might occur as a result of the person having access to the record, the statute[14] requires the treating practitioner to consider, among other things, the following:

(i) the need for, and the fact of, continuing care and treatment;

(ii) the extent to which the knowledge of the information contained in the clinical record may be harmful to the health or safety of the patient or client or others;

(iii) the extent to which the clinical record contains sensitive information disclosed in confidence to the practitioner or treating practitioner by family members, friends and other persons;

(iv) the extent to which the clinical record contains sensitive information disclosed to the practitioner or the treating practitioner by the patient or client which would be injurious to the patient's or client's relationships with other persons except where the patient or client is requesting information concerning himself or herself; and

(v) in the case of a minor making a request for access, the age of the minor.

There is a statutorily mandated appeals process for those situations wherein access to a record has been denied. In the event of such denial, MHL § 33.16(c)(4) provides that the individual must be informed that access has been denied, and that he or she has the right to obtain, without cost, a review of the denial by the appropriate clinical record access review committee.[15] If such review is requested, the facility shall, within ten days of receipt of such request, transmit the record to the chairman of the appropriate committee with a statement setting forth the specific reasons access was denied. After an *in camera* review of the materials provided and after providing all parties a reasonable opportunity to be heard, the committee must promptly make a determination whether the requested reviews of the record can reasonably be expected to cause substantial and identifiable harm to the patient or client or others which outweighs right of access to the record, whether the requested review would have a detrimental effect on the practitioner's professional relationship with the minor, or on the care and treatment of the minor or on the minor's relationship with his or her parents or guardians. If the committee determines that the request for access should be granted in whole or in part, the committee shall notify all parties and the facility shall grant access. MHL § 33.16(c)(5) provides that if access is denied in whole or in part, the committee must notify the individual of the right to seek judicial review of the facility's determination. Within thirty days of receiving notification of the decision, the individual may commence, upon notice, a special proceeding in State Supreme Court for a judgment requiring the provider to make available the record for inspection or copying. A court which receives such application shall conduct an *in camera* review of the materials provided, including the determination and record of the committee, and after providing all parties an opportunity to be heard, shall determine whether there exists a reasonable basis for the denial of access. The only relief available is a finding that the facility should make available the requested record for inspection or copying.

Importantly, the law provides that "no proceeding shall be brought or penalty assessed" against a facility "which in good faith, denies access to a clinical record." In addition, facilities, treating practitioners, mental health therapists and others, and clinical records access review committee members are immune from civil liability arising solely from granting or providing access to any clinical record in accordance with this section. MHL § 33.16(k).

One of the most important points about the sharing of clinical information that is misunderstood by many is that MHL § 33.13(d) allows service providers to share

information regardless of the parent(s) or guardian(s) consent, or that of the minor. Providers responsible for the provision of services for current or former patients may share with each other information necessary to provide services, provided that there is some nexus or link with OMH through licensure, a local government's service plan, or an agreement. It should be noted that information can also be disclosed to entities which are responsible for the provision of services which are not mental health services, such as Child Protective Services, if the entity has an agreement with OMH that allows the sharing of such information[16] or consistent with standards developed by OMH.

"As can be seen, there are unresolved issues in the law concerning the treatment of minors by mental health providers, and little guidance from the case law."

Finally, the question exists as to whether the Health Care Portability and Accountability Act (HIPAA) preempts the Mental Hygiene Law in any respect as to the confidentiality of the clinical record. The rule of law under HIPAA is that HIPAA does not replace federal, State, or other law that grants individuals even greater privacy rights. There do not appear to be any instances in which HIPAA is more stringent in its confidentiality provisions than the existing State statutes, MHL § 33.13 and 33.16.

Conclusion

As can be seen, there are unresolved issues in the law concerning the treatment of minors by mental health providers, and little guidance from the case law. The statutory framework can also be confusing since at times notice of a decision is required even though the decision itself would not appear open to legal challenge by the party receiving the notice. This confusion reflects society's confusion about juvenile rights. In our society one can vote at eighteen and be drafted, two hallmarks of full citizenship, yet cannot consume alcohol until the age of twenty-one. Health care law is similarly inconsistent in some areas, particularly in the area of the rights of "mature minors."

Endnotes

1. "Next of kin" is not defined in the Mental Hygiene Law.
2. In cases of emergency, treat regardless of consent. However, once the emergency has passed, parental consent must be obtained or other methods of obtaining consent pursued. The only definition of what constitutes an emergency is in Public Health Law § 2504(4) which provides that,

   > Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and **the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health**. [Emphasis added.]

3. Social Services Law § 371(4-a) defines a neglected child, in part, as one "whose physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care . . . in supplying the child with adequate . . . medical or surgical care . . ."
4. There is no statutory definition of what constitutes emancipation, and the most conservative view is that emancipation therefore should be defined as legal emancipation. The burden of proving emancipation is on the person who asserts it.
5. *See also Zinermon v Burch* 494 U.S. 113 (1990) for the constitutional basis for this premise, albeit in a case dealing with a voluntary adult patient.
6. It should be noted that the case of *Rivers v. Katz*, 67 N.Y.2d 485, (Court of Appeals 1986) wherein the New York State Court of Appeals determined that patients who objected to the administration of psychotropic medication could not be administered such medication absent a court order, does not apply to minors. The Court made it clear that the decision only applied to adults. The Court stated that, "It is a firmly established principle of the common law of New York that every individual 'of **adult** years and sound mind has a right to determine what shall be done with his own body. . .'" (Emphasis added.)
7. Section 2504 refers to "emancipated minors."
8. That section defines "reasonably available" as "a parent or guardian can be contacted with diligent efforts by a mental health practitioner."
9. A minor is defined as a patient under the age of 18, not married, not the parent of a child, not on voluntary status on his or her own application. 14 N.Y.C.R.R. § 527.8(a)(5).
10. See *supra* note 2.
11. Surgery, ECT, major medical treatment in the nature of surgery, and use of experimental drugs or procedures can never be provided without parental consent.
12. MHL § 33.13(c) sets forth the exceptions. Briefly, the exceptions are as follows:
    - pursuant to an order of a court of record requiring disclosure upon a finding by the court that the interests of justice significantly outweigh the need for confidentiality;
    - to the Mental Hygiene Legal Service;
    - to attorneys representing patients or clients in proceedings in which the patients' or clients' involuntary hospitalization or assisted outpatient treatment is at issue;
    - to the Commission on Quality of Care for the Mentally Disabled and any person or agency under contract with

the commission which provides Protection and Advocacy services . . . as provided for by federal law;

- to the Medical Review Board of the State Commission of Correction when such board has requested such information with respect to the death of a named person, or, with the consent of a patient or client when such board has requested information about the patient or client;
- to an endangered individual and a law enforcement agency when a treating psychiatrist or psychologist has determined that a patient or client presents a serious and imminent danger to that individual;
- with the consent of the patient or client or of someone authorized to act on the patient's or client's behalf, to persons and entities who have a demonstrable need for such information and who have obtained such consent, provided that disclosure will not reasonably be expected to be detrimental to the patient, client or another provided, however, that release of such information to a patient or client shall not be governed by this subdivision;
- to the State Board for Professional Medical Conduct or the Office of Professional Discipline or their respective representatives . . . provided, however, that no such information shall be released when it concerns the subject of an inquiry who is also a patient or client, except pursuant to paragraph one of this subdivision;
- with the consent of the appropriate commissioner, to: (i) governmental agencies, insurance companies licensed pursuant to the insurance law and other third parties requiring information necessary for payments to be made to or on behalf of patients or clients pursuant to contract or in accordance with law . . . (ii) persons and agencies needing information to locate missing persons or to governmental agencies in connection with criminal investigations, such information to be limited to identifying data concerning hospitalization. (iii) qualified researchers upon the approval of the institutional review board or other committee specially constituted for the approval of research projects at the facility, provided that the researcher shall in no event disclose information tending to identify a patient or client. (iv) a coroner, a county medical examiner, or the chief medical examiner for New York City upon the request of a facility director that an investigation be conducted into the death of a patient or client for whom such record is maintained. (v) appropriate persons and entities when necessary to prevent imminent serious harm to the patient or client or another person, provided, however, nothing in this subparagraph shall be construed to impose an obligation to release information pursuant to this subparagraph. (vi) a district attorney when such request for information is in connection with and necessary to the furtherance of a criminal investigation of patient or client abuse;
- to a correctional facility, when the chief administrative officer has requested such information with respect to a named inmate of such correctional facility as defined by subdivision three of section forty of the Correction Law or to the Division of Parole, when the Division has requested such information with respect to, a person under its jurisdiction;
- to a county Director of Community Services . . . provided that such director or his or her designee requests such information in the exercise of his or her statutory functions, powers and duties pursuant to Section 9.37, 9.45, 9.47, 9.48, 9.60 or 41.13 of the MHL;
- to the State Division of Criminal Justice Services for the sole purposes of providing, facilitating, evaluating or auditing access by the Commissioner of Mental Health to criminal history information . . .

Importantly, subdivision (d) provides that, "Nothing in this section shall prevent the electronic or other exchange of information concerning patients or clients, including identification, between and among (i) facilities or others providing services for such patients or clients pursuant to an approved local or unified services plan, as defined in article forty-one of this chapter, or pursuant to agreement with the department, and (ii) the department or any of its licensed or operated facilities."

Additionally, subdivision (f) provides that, "Any disclosure made pursuant to this section shall be limited to that information necessary in light of the reason for disclosure. Information so disclosed shall be kept confidential by the party receiving such information and the limitations on disclosure in this section shall apply to such party."

13. MHL § 33.16 defines the "treating practitioner" as the practitioner who has or had primary responsibility for the care of the patient or client within the facility, or if such practitioner is unavailable, a practitioner designated by such facility.
14. MHL § 33.16(c)(3).
15. The Commissioner of Mental Health, the Commissioner of Mental Retardation and Developmental Disabilities and the Commissioner of Alcoholism and Substance Abuse Services shall appoint clinical record access review committees to hear appeals of the denial of access to patient or client records.
16. If a practitioner has a question as to whether such an agreement exists, the nearest OMH Field Office should be contacted.

Ms. Tindall-O'Brien is an Associate Attorney for the New York State Office of Mental Health. However, the opinions expressed in this article are solely hers and do not necessarily reflect the policy of the New York State Office of Mental Health.

Mental Health Issues on College Campuses

By Lydia Hoffman Meunier and Carolyn Reinach Wolf

Introduction

Several recent and much-publicized campus suicides have drawn attention to the issue of increasing numbers of students on campus with a diagnosed mental illness and highlight the challenges this issue poses to educational institutions. A less visible, but equally troubling challenge, is the increase in the number of students on campus experiencing all forms of psychiatric disorders. In a recent survey, over 90% of the directors of college counseling centers stated that the problems presented by students with significant psychological disorders are a growing concern on campus.[1] Claims data also indicates that in recent years demand for mental health services on campus has increased steadily and, in some cases, dramatically.[2]

This article examines the impact of the increased incidence of mental illness on campus, the inherent legal issues in managing mental illness in the campus setting, and discusses a much-anticipated decision in a Massachusetts case, *Shin v. Massachusetts Institute of Technology*. In the *Shin* case, the parents of a student who committed suicide in her dorm room sued the Massachusetts Institute of Technology. The school's motion for summary judgment was granted on several claims, but denied with respect to the claims of negligence against the counseling center's medical staff and school administrators. The *Shin* case illustrates that post-secondary institutions must now recognize, evaluate, and appropriately respond to the increasing numbers of students experiencing psychiatric problems on their campuses in a way that protects students as well as the institution.[3]

The Problem

Most students enter college at a developmentally pivotal time. Students are likely to be dropped at their freshman dorm by parents whom they have lived with their entire lives. Adjusting to the relative freedom and autonomy of campus life, increased academic demands, and an entirely new social milieu will be managed differently by every student. Traditionally, counseling centers have dealt with roommate disputes, relationship issues, substance abuse, academic anxieties and identity issues. More recently, campus counselors report that in addition to typical adjustment problems, counselors are increasingly seeing clients with severe psychological problems, and of those many have significant psychological disorders.[4] While mostly anecdotal, it appears that a perfect storm of factors are contributing to placing a greater number of vulnerable people on campus.[5]

Psychiatric diagnosis and treatment have progressed rapidly in recent years. Many conditions such as mood disorders, anxiety disorders and eating disorders were barely recognized a generation ago. With recognition came treatment, especially medication, that can dramatically diminish symptoms and permit those affected to function far closer to their potential than in years past. As a result, students who would otherwise have been precluded by their mental illnesses from completing high school are able to do so successfully, and to enroll in colleges and universities.

A positive societal adjustment is also at play as the stigma of mental illness is decreasing. Awareness of the prevalence, variety, and ability to treat mental illness has increased, and the acceptance of those in our midst who are affected with mental illness has likewise increased. It is not unusual for children to be medicated at an early age for conditions such as attention deficit disorder and hyperactivity disorder. The prospect of individuals with psychiatric disorders living and working among us is no longer a frightening anomaly.

Many psychiatric conditions develop or are discovered in early adulthood. Conditions such as depression and bipolar disorder often develop at this time. Anxiety disorders, including panic disorder and obsessive compulsive disorder, may be triggered by stressors, including those typical of campus life. Eating disorders, such as anorexia nervosa and bulimia nervosa, are most likely to develop during these years. Substance abuse may also become apparent in the campus environment. More severe psychiatric disorders, including schizophrenia and other conditions associated with psychosis often develop in late adolescence.

Students may be slow to recognize the symptoms of many of these disorders. Most symptoms, such as insomnia or increased sleep patterns, weight gain or loss, restlessness, fatigue, mood swings, increased anxiety, worry and tension, inconsistent eating habits, and the use of drugs and alcohol are probably an aspect of most students' experiences at college. Often, considerable time passes before the student recognizes these symptoms constitute a problem. Once a student has come to recognize he or she needs help and seeks assis-

tance, it may be some time before a condition is stabilized. However, students who do seek help for a psychiatric disorder that develops while at college stand a very good chance of being effectively treated, and are often able to resume or maintain their presence at school.

The increased demands on college counseling centers is attributable in large part to these essential changes in the treatment and perception of mental illness. It is essential that schools recognize the issues attendant to a student population that includes those with psychiatric disorders, and develop strategies to manage mental health issues in a way that protects both the institution and the students.[6]

The Parties

College campuses are typically micro-societies consisting of students, administration, and staff functioning as a self-contained unit within a larger community. In this context, the impact of even a single student experiencing symptoms of a psychiatric disorder is likely to affect most components of the campus community.

Counselors and Counseling Centers

The range of mental health services available on campus can vary widely, but on all campuses, college counseling centers are on the front line in evaluating and responding to the increasing incidence of mental illness on campus. A core mission of college counselors has been identified as "improving retention and graduation rates" through their work.[7] At a minimum, counseling centers must address the needs of students who come to the center seeking assistance by assessing the severity of the student's condition and providing medically appropriate treatment. In light of the *Shin* decision, this basic activity must be re-evaluated by the counseling center and the administration. Counseling centers must now be cognizant of the duty to assure the safety of these students and even others on campus under some circumstances.

Most campus counseling centers are also actively involved in education and outreach efforts to identify at-risk students and encourage them to seek treatment. As the number of students arriving on campus with a history of a psychiatric disorder increases, the counseling center may assume an oversight role in managing these students' illnesses and medications. As a component of the institution, campus counseling centers are also uniquely challenged to dodge potential conflicts of interest and confidentiality breaches. Campus counseling centers also may find challenges in continuity of care, as students leave campus and possibly experience stressful situations without the benefit of ongoing counseling.

Students

An inevitable feature of the prospective freshman's campus tour is a recitation of the resources available to meet student needs and security measures to assure student safety. Students do not typically arrive on campus concerned about their personal safety or believing that the school will fail to meet the student's health needs.

Students who are diagnosed with a psychiatric disorder or who have experienced symptoms of mental illness before attending college or university may or may not disclose this fact to the schools. Most schools do not directly ask students to disclose information pertaining to mental health history, but may ask about prescribed medication or general ongoing health concerns. Students may not feel comfortable disclosing this information before they even arrive on campus, as they are uncertain about with whom it will be shared and whether it will affect them socially or academically.

"It is essential that schools recognize the issues attendant to a student population that includes those with psychiatric disorders, and develop strategies to manage mental health issues in a way that protects both the institution and the students."

At most campuses students attend classes together, eat together, socialize together and live in close proximity to one another. It may be readily apparent to other students when a student is experiencing psychological problems. It is not unusual for students to assume a duty in caring for their peers who are experiencing symptoms of mental illness, particularly when the affected student is reluctant to seek counseling services. Students who share living space will inevitably be affected by the condition of their peers, and may find themselves in the demanding role of monitoring and counseling a peer. Schools may place a burden on students in a supervisory role, such as Resident Assistants, to refer students to counseling and report instances of concern, and outreach programs typically encourage students to be involved in getting others to treatment.

Parents

Most students entering college are, or soon will be, eighteen and are therefore adults for most purposes. But there is a distinct and growing expectation that parents will play a continuing role in their offsprings' lives. The phenomena of parents hovering over their adult offspring has been identified as "helicopter parenting." This emerging trend is attributable to many factors, including smaller families, the increased cost and competition of education giving rise to a sense of entitlement, increased communication modes, such as instant messaging and cell phones, that allow parents to closely track activities, and intimate parental involvement in their children's academic, sports and leisure activities throughout childhood.[8] Helicopter parents expect to be well-informed by their children and by their children's schools. These parents expect their children's needs, as expressed by their children, to be promptly addressed and are not shy about intervening, with or without their children's knowledge. Colleges note that today's parents are not hesitant to make demands on college administration and services and expect institutions to be responsive to their concerns.

Administration

An incident involving a mentally ill student, particularly a student suicide, is devastating to the administrators and staff involved and impacts the entire campus community. The public reaction to such an event can be similarly difficult. Less dramatic, but more common and nonetheless disruptive, a student struggling with a psychiatric disorder may impact a roommate, a dormitory, a classroom or the entire campus. A student's mental illness may potentially affect the academic performance of the ill student (and those around him or her), and ultimately could affect admission, retention, and graduation rates. Campus resources must be stretched to meet these existing needs. Finally, there are many potential legal liabilities for colleges and universities related to their treatment of the mentally ill student.

The administration's approach to this issue must balance protecting the individual student with the integrity of the institution. From a public relations standpoint, prospective students may be seeking evidence that the school provides extensive counseling services. An institution's ability to address student mental health needs is even becoming a factor in college application decisions.[9] Conversely, students may perceive incidents such as campus suicide as evidence that a college is unable to meet student needs.

Potential Pitfalls

Confidentiality and Disclosure

Campus counseling centers are uniquely challenged to meet their obligation to maintain patient confidentiality set out in professional ethical standards as well as in law and regulations.[10] Counseling centers report that parents, administration, and other departments of a college or university often feel entitled to confidential information. The college community setting also presents special challenges in preventing disclosure. In contrast, recent cases have indicated that schools *should* disclose under some circumstances, and could face liability if they fail to do so. Institutions should be prepared and willing to consult legal counsel with specialized expertise in mental health, psychology, risk management, or privacy law, either alone or as co-counsel to university counsel to review present policies and address specific disclosure questions. Advice and counsel regarding these and related matters should be available and accessible to ensure preventive measures are in place and to respond appropriately in a crisis.

Applicable Regulations

The treatment relationship has long been subject to confidentiality rules. In general, providers, including psychiatrists, psychologists, and social workers, are prohibited from disclosing treatment information for adult patients. Under state licensing laws, such disclosure would constitute professional misconduct. Federal regulations also prohibit disclosure of health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). HIPAA does not apply to education records covered by FERPA.[11] FERPA establishes a series of privacy protections and access requirements related to educational records. FERPA defines "educational records" as "those records, files, documents, and other materials" that (1) contain information directly related to a student; and (2) are maintained by an educational agency or institution or by a person acting for such agency or institution. Records maintained by campus counseling centers are generally subject to FERPA. It is conceivable that records created and maintained by a campus-based clinic that is not funded or run by the university would not be subject to FERPA, but this material would then be subject to HIPAA. In any event, the records remain subject to state privacy rules. While there is no private right of action for violation of either HIPAA or FERPA, there are substantial civil penalties for a violation of these rules, including termination of all government funding of a college or university.

Potential Disclosures

Counseling centers report that it is not uncommon for a student's parents to expect notification of any conditions affecting their children. Parents may be dismayed to learn that if their child is eighteen, federal and state law generally provide that their child's written consent is required for disclosure of education and health information. Students who are struggling at school may be very reluctant to authorize disclosure to parents. Schools must determine whether and when it is appropriate to break confidentiality rules and communicate a student's condition to family. It has been our experience in counseling a variety of health care facilities on this issue, that the facts may dictate a "pick your liability" dilemma, and the advice of counsel is essential in weighing the choices.

The close proximity of students and the frequent contact with staff inevitably result in a community of shared knowledge. Students and staff may contact the counseling center with their concerns about a particular individual, and may feel responsible for assuring that the troubled student is receiving treatment. The small size and limited resources of many campus counseling centers may also result in unintentional disclosures. Counseling centers have described situations where confidentiality is compromised by student employment at the centers, students encountering one another when seeking treatment, and one counselor even described a practice of conducting admission tours through the counseling center.[12]

Intra-facility Disclosures

In addition to the professional and legal conflict of interest rules applicable to all counseling professionals, the accreditation standards promulgated by the International Association of Counseling Services note that,

> it is critically important that the service be administratively neutral. If it is perceived as being linked with units that are involved in making admissions, disciplinary, curricular, or other administrative decisions it can severely restrict the utilization of the service. Such perceptions may prevent students from seeking services for fear that information they disclose may negatively affect their college careers.

It is not uncommon for the administration to believe that, as an entity within an institution, the counseling center is subject to the greater interests of the institution. Typically, the Dean of Students, or similar administrative office, is charged with overseeing all issues related to students' well-being on campus. While it is natural and desirable for this office to work closely with counseling professionals, these interests may nonetheless diverge.

The administration or other departments on campus may feel entitled to confidential student information as a matter of course. Examples raised by counseling staff include requests for information for use in housing determinations, to be provided to resident advisors; for inclusion in records for special programs, such as study abroad or internships or as needed to prepare recommendations for programs, such as the Peace Corps or federal agencies; for use in preparing statistical information; and for use in readmission decisions. Counseling centers have also been requested to provide student health information in special situations. For example, counseling centers have been asked to provide information in the defense of a lawsuit brought by a former counseling client against the university in which the counseling center is not a party. Similarly, information was requested for use in investigating a sexual harassment claim by a student counseling client against a staff member. Some counselors report that deans have demanded to be provided with information on all clients who have expressed any suicidal ideation and some request forensic information on clients.

The administration may ask the counseling centers to evaluate whether a student should continue or be readmitted to school following an incident of concern to the administration. This is particularly troubling if a student had been in treatment with the evaluating counselor. A variation of this request is an administrative request for an evaluation of a student client's readiness for a particular academic program. Depending on a particular institution's policy toward students with mental illness, the counseling center may be asked to evaluate a student upon admission, if a history of mental illness is disclosed, in order to determine the reasonable accommodations the facility must or is able to provide to the student, should he or she be admitted.

In addition to penalties for violating state and federal privacy rules, the institution and/or counseling center staff could face liability and monetary penalties for damages resulting from such disclosures. If an institution violates confidentiality by improperly providing information to a potential employer or graduate school, and it can be shown this resulted in the student not obtaining employment or admission, the disclosing institution will certainly be vulnerable. Counseling staff have reported administration requests for client information for use in a client's application for admission to

the bar (the state was not specified). An illegal disclosure in this circumstance would certainly create potential liability.

While it is difficult to imagine a student prevailing against a university for damages the student incurred as a result of a disclosure that prevented the student's suicide, it is not so difficult to imagine in some of the other disclosures discussed above. Campus counseling centers and the administration must be aware of when intra-facility disclosures are necessary and permitted, or even required, and when a disclosure would violate confidentiality rules.

Americans with Disabilities Act and the Rehabilitation Act

Students with mental illness are afforded protection under both the Americans with Disabilities Act and the Rehabilitation Act of 1973. Under these laws, "reasonable accommodation" must be made for those with disabilities and an individual may not be denied participation by reason of his or her disability. Most psychiatric disorders are a disability under both laws.

Section 504 of the Rehabilitation Act of 1973 (the "Rehab Act") and implementing regulations require that all post-secondary institutions receiving federal funding (virtually all colleges and universities) must make their programs accessible to students with psychiatric disabilities who are "otherwise qualified."[13] This rule is applicable to the admissions process, as institutions are prohibited from having eligibility requirements that screen out those with disabilities and applicants may not be asked if they have a disability, including a history of mental illness. The Rehab Act is applicable to the enrolled student, as the institution is required to make reasonable accommodation for the individual's disability, including psychiatric disabilities. Any criteria that are imposed by an institution must be based on actual risk and not on stereotypes or assumptions. The prohibition on excluding an individual from, or denying participation in, a post-secondary program by reason of his disability will also be implicated in an institution's decision to dismiss a mentally ill student.

The Americans with Disabilities Act (ADA) was enacted in 1990, several years after the Rehab Act. The ADA extended the protections of the Rehab Act to a much wider realm, and created other protections for those with disabilities. The ADA imposed administrative requirements, but had little practical effect on colleges and universities, as most institutions were required to implement the provisions of the Rehab Act years before. Institutions that are not subject to the Rehab Act are almost certainly subject to the ADA.

A disabled person who requests and does not receive accommodation under either the Rehab Act or ADA may make a complaint to the Office of Civil Rights of the U. S. Department of Education. Both the Rehab Act and the ADA provide a private right of action. A complainant may seek injunctive relief and may even win monetary damages if the discrimination is determined to be intentional.

In Loco Parentis

The doctrine of *in loco parentis*, wherein an institution stands in the place of parents, has been much discussed in the context of an institution's responsibility and liability for student safety. The doctrine has come to be applied to the concept of colleges' and universities' responsibility for the safety of a student's character and morals, as well as the student's physical well-being.[14] Although traditionally *in loco parentis* was applied as "a shield for colleges, not a sword for students" allowing institutions to impose authority on students,[15] New York courts have cited this doctrine (or more accurately the abandonment of this doctrine) in discussing the absence of a duty running from the institution to their students. Under this reading of *in loco parentis* by New York courts, universities and colleges have enjoyed a general aura of protection from negligence claims. Other theories negating institutional liability include charitable immunity, governmental immunity, proximate cause rules (cases have held that injuries were not proximately caused by universities, but by intervening, superceding events, such as an attacker or the illegal use of liquor), and contributory negligence theories.

Nationally, a trend away from a general protection from liability has been identified and attributed to the erosion of immunities in tort law, the demise of contributory negligence, increased awareness and disapproval of excessive use of alcohol, and the swinging of the societal pendulum back toward parental involvement and oversight in the lives of their children, even children over the age of eighteen.[16] FERPA is a signpost on this road. Passed in 1974 in the wake of student activism and the lowering of the voting age in 1972 as part of a movement to treat those over eighteen as autonomous adults, FERPA effectively codified the privacy rights of students over eighteen. However, in response to the increase in the drinking age from eighteen to twenty-one, FERPA was amended in 1998 to permit colleges to overrule students' wishes and inform parents of students under age twenty-one when a drug

or alcohol law is broken. Recently, courts in several jurisdictions have been holding that, under certain circumstances, there *can* be a duty running from an educational institution to students, and institutions should no longer rely on the absence of *in loco parentis* responsibilities to insulate them from liability when students are injured on campus. The shift toward campus responsibility has occurred incrementally, with cases looking closely at the facts leading to injury, and particularly the foreseeability of an incident.

Recent cases have held that educational institutions had a duty to students in cases involving injuries resulting from an assault in a campus dorm,[17] fraternity hazing incidents,[18] alcohol excesses,[19] injuries to athletes,[20] and injuries related to a student's mental illness.[21] In each instance, the court held that the institution was, or should have been, aware of the likelihood of injury because of the pattern of behaviors or events leading up to the injury.

Although New York cases have generally not found a duty running from the institution to individual students, these cases have uniformly noted that in those cases the institution had no notice of the conditions that led to a student's harm.[22] In a factually appropriate case, it is quite possible that a New York institution could be held liable for injury inflicted by a student on him or herself or another. For example, a fact pattern in which a mentally ill student harms him or herself or another student on campus is very likely to involve the kind of behavior and contacts with administration and staff that would make such an injury foreseeable in the eyes of a court. This was precisely the case in *Shin v. Massachusetts Institute of Technology.* In this 2005 opinion, the plaintiff withstood a motion for summary judgment on a claim for wrongful death of a student who committed suicide in her dorm room following a substantial and well-documented deterioration of her mental condition. The case has significant implications for the way colleges and universities handle students suffering from a mental illness.

The *Shin* Case

Elizabeth Shin entered MIT in 1998.[23] The following February she was taken by ambulance to Massachusetts General Hospital when her boyfriend found Elizabeth was acting disoriented following an alleged overdose of Tylenol with codeine. According to her parents, Elizabeth denied this was a suicide attempt, and Elizabeth claimed that she took what she thought would be a sufficient dose of the prescribed medication to afford her a good night's sleep following a diagnosis of mononucleosis. During her week-long hospitalization, MIT court papers claimed that Elizabeth revealed that she had mental health problems while in high school (her parents claim not to have known this). Elizabeth's housemaster contacted Elizabeth's parents who met with Elizabeth's treating physicians and social workers.

Before her discharge, Elizabeth's father met with Dr. Kristine Girard, one of the full-time psychiatrists at the Mental Health Services department (counseling center) at MIT, and it was agreed that, upon discharge, Elizabeth would resume classes at MIT and she would see Dr. Girard every 2-3 weeks. Dr. Girard met with Elizabeth three times between February and May. She diagnosed Elizabeth with "adjustment disorder" and later noted she was suffering from "situational issues." At the end of the term, Dr. Girard recommended more therapy upon her return to campus for her sophomore year.

Elizabeth spent an uneventful summer with her parents at home in New Jersey. She returned for the fall term at MIT and did not visit the counseling center until early October, following a break-up with her boyfriend. During this time, Elizabeth was engaged in cutting behavior, something she had done in high school. The psychiatrist who met with Elizabeth at the counseling center noted general symptoms of mood disorder, such as reduced sleep and erratic eating habits, but felt she was in no immediate danger. Elizabeth returned to the counseling center about a week later, and met again with Dr. Girard. She claimed she was feeling "significantly better," but the doctor noted an "underlying sadness."

In November, Elizabeth's friends, concerned about her cutting activity, urged her to meet with Dean Arnold Henderson, and she did so, showing the Dean the scratches on her arm, at the Dean's request. The Dean made an appointment at the counseling center, but it is unclear whether this meeting occurred. In December, Dean Henderson received an e-mail from Elizabeth that was forwarded by one of Elizabeth's professors indicating that Elizabeth said she had bought a bottle of sleeping pills with the intention of using them to overdose, but she had changed her mind. The Dean contacted Elizabeth, but she appeared to be doing well. The Dean reported the incident to Dr. Girard.

It was not until several months later that Elizabeth's behavior again began to worry those around her. Just before spring break, early in the morning on March 18, 2000, following another break-up with a boyfriend, a student notified the housemaster that Elizabeth was extremely upset and was cutting herself. She was taken immediately to the MIT campus infirmary, where the physician who examined Elizabeth contacted the on-call

psychiatrist. The psychiatrist admitted Elizabeth to the infirmary, as it was determined it would not be safe to return Elizabeth to her dorm.

The following day, Elizabeth was discharged back to her dorm, where students reported she remained distraught. Shortly thereafter, her parents arrived to bring her home for spring break. Elizabeth's parents were informed that she had been admitted to the infirmary, but they contend they were not told why she had been admitted, and Elizabeth refused to discuss it. Her parents stated that she appeared to be fine while she was home for break, and they saw no reason to keep her home. Upon her return to school however, her housemaster received numerous reports from students and graduate resident tutors in her dorm that her condition was deteriorating. Friends were staying up with her at night to assure her safety.

On March 23, Elizabeth was seen by a new psychiatrist at the center, Dr. Linda Cunningham, who noted she was experiencing a "severe" depressive episode, and prescribed anti-depressant medication. On subsequent visits through the end of March, Dr. Cunningham noted that Elizabeth might require hospitalization. During the first week in April, Elizabeth contacted Dean Henderson's office about rescheduling exams and the Dean agreed, remaining in contact with her housemaster about her condition. Elizabeth also had several therapy sessions with Dr. Cunningham at the MIT Mental Health Department, and arrangements were made for Elizabeth to be evaluated for therapy at a clinic off campus. On April 5 and 6, two of Elizabeth's Spanish instructors expressed concern about cuts on Elizabeth's arms. After one instructor placed four calls to Dean Henderson, she was informed there was no need to be concerned because action was being taken to assure Elizabeth's safety.

On the evening of April 8, 2000, Elizabeth informed another student in her dorm that she intended to kill herself with a knife. The student called campus security, and Elizabeth was taken to the Mental Health Center. The staff physician contacted the on-call psychiatrist, Dr. Anthony Van Niel, who spoke with Elizabeth briefly on the phone, and determined that Elizabeth was not acutely suicidal. Elizabeth was returned to her dorm with no restrictions or follow-up planned.

On April 9, 2000, Elizabeth's parents visited her for the afternoon. They noted that Elizabeth looked a bit tired and harried, but nothing about her appearance or behavior led them to be concerned. She discussed plans for the week ahead and plans for the future. No one at MIT disclosed to Elizabeth's parents her frequent visits to the counseling center or their concerns about her recent behavior.

About 12:30 a.m. on April 10, 2000, two students notified the housemaster that Elizabeth requested that a student erase her computer files, as she planned to kill herself that day. The housemaster called the Mental Health Center and her call was returned by Dr. Van Niel. Dr. Van Niel told the housemaster to check on Elizabeth, but that it was not necessary to bring her to the Center as Elizabeth had assured Dr. Van Niel that she was fine and Elizabeth's friends had overreacted two days before. The housemaster checked on Elizabeth at 6:30 a.m., and decided not to wake her, as all was quiet. The housemaster conveyed these events to Dean Henderson, as a "deans and psychs" meeting was scheduled later that morning. A little later, around 9:45 a.m., Elizabeth called the housemaster and accused her of wanting to send her home, and stated words to the effect that the housemaster would not have to worry about her anymore. The housemaster again called Dean Henderson, and he assured the housemaster that the conversation would be mentioned at the meeting.

Elizabeth's case was discussed at the "deans and psychs" meeting held at 11:00 a.m. on April 10, 2000. An appointment was made for Elizabeth at an off-campus facility, and a message was left with Elizabeth notifying her of the appointment.

Shortly before 9:00 p.m. that same day, the smoke alarm in Elizabeth's room went off. Campus police and the Cambridge Fire Department found Elizabeth engulfed in flames. She was transported to Massachusetts General Hospital, with third degree burns over 65% of her body. Four days later, her parents were told that she had suffered irreversible neurological brain damage and life support was terminated.

Two years later, in 2002, Elizabeth Shin's parents filed a lawsuit against MIT, as well as the clinicians at the MIT Mental Health Center, two Deans, and the housemaster, claiming breach of contract, gross negligence, negligent infliction of emotional distress, and a violation of the Massachusetts' consumer protection statute. The plaintiffs contended that defendants failed to inform them of their daughter's condition and the opportunity to oversee her care, and that the defendants failed to provide adequate coordinated care for her. The defendants moved for summary judgment dismissing the claims. The Court granted summary judgment on the breach of contract, consumer protection and negligent infliction of emotional distress claims, but denied summary judgment on the claim of gross negligence against the dean, the housemaster, and the psy-

chiatrists. The defendants claimed that there was no duty running from the defendants to Elizabeth Shin. However, the Court held that the number and nature of contacts between defendant physicians, administrators and housemaster was sufficient to establish that defendants "could reasonably foresee that Elizabeth would hurt herself without proper supervision. Accordingly, there was a 'special relationship' between the MIT Administrators, Dean Henderson, [the housemaster], and Elizabeth imposing a duty [on the defendants] to exercise reasonable care to protect Elizabeth from harm."

The *Shin* court cited *Schieszler v. Ferrum College*, in which the court also found a special relationship running from the institution to the student which was sufficient to meet the burden on summary judgment of the existence of a special relationship between the college and the student, giving rise to a duty of care. The Court denied defendant's summary judgment motion, holding that the student's several contacts with the campus police, the dean and the dormitory resident assistant indicating the student's intent to take his life, could lead a trier of fact to conclude that there was "an imminent probability" that the student would try to hurt himself, and the defendants had notice of this specific harm. The defendant's failure to contact the student's guardian with information about threats to harm himself supported the plaintiff's allegation that the college breached a duty of care to the student. This case was eventually settled.

The factual basis for the holding in these cases should give institutions of higher learning pause. It is clear that courts will look specifically at how a student's needs are handled by a particular administration and counseling center, and lofty concepts, such as *in loco parentis,* will not protect an institution where the facts indicate the institution knew of a threat and did not act to prevent harm. The summary judgment rulings in *Shin* and *Schieszler* did not address the difficult issue of whether defendants were actually responsible for preventing the troubled students' suicides as the Court did not reach the question of causation on summary judgment. However, the holding that the schools had a duty to the students is significant. Both *Shin* and *Schieszler* plaintiffs alleged that the schools' failure to notify the students' parent/guardian was a factor in causing each student's death. Both Courts agreed, holding that there was an obligation to notify the students' parents and guardian of an imminent potential threat of which the school is aware and which the parent or guardian may be able to prevent. The duty to notify is in direct contravention of confidentiality requirements, and schools must tread a careful path in the decision to disclose confidential patient information. While duty is just one element of a negligence claim, the acceptance of a duty running from the institution to a student is a substantial change in the law with significant consequences.

Responding to the Issue

Post-secondary institutions must recognize and respond to the increased number of students with psychiatric disorders on campus. The possibility of liability arising from a duty to respond to foreseeable injuries requires institutions of higher learning to examine what would constitute a breach of this duty and how to reduce this liability. Even as most institutions report stepped-up efforts to meet student mental health needs—such as increasing staff training, more counseling staff, adding counseling hours, and part-time counseling staff during peak demand periods—these efforts are not enough, as about 75% of counseling centers surveyed believed that their centers continue to require more hours based on client needs, stating that present psychiatric hours were "woefully inadequate."[24] In addition, institutions have begun to intensify outreach programs, including providing information on mental health services at orientation; training for faculty, staff, and residence personnel; regular education programs, education materials sent to students and parents; and mental health screening days in an effort to identify and serve those on campus with psychiatric issues.[25] Despite these efforts, it appears that many institutions have not reconciled their policies with the reality of a responsibility to protect students from foreseeable harm.

In an on-line forum discussing the *Shin* case, some participants strongly expressed the feeling that institutions should bear no responsibility for the mental health of their students, that students at risk of harm should be removed from campus housing, and possibly from the institution entirely. Some noted that the case would have a chilling effect on the admission of students with certain disorders, or worse yet, would prevent students from getting the help they need.[26] Some institutions have taken a tack of essentially weeding out students as soon as their symptoms become manifest by imposing a choice between an involuntary medical leave or a voluntary leave of shorter duration.[27] Students experiencing psychiatric disorders may also engage in behavior that violates the rules of student conduct, and colleges may offer a "choice" between voluntary medical leave or disciplinary action. This course of action could constitute "intentional" discrimination under the Rehab Act and ADA and legal counsel should certainly be con-

sulted if an institution elects to remove risky students in this manner.

A far more effective and practical solution is to address the issue directly so that the institution is in a position to demonstrate that even if there is a duty to an injured student, the institution will not be in breach of that duty. The administration must demonstrate a recognition that mental health services are a critical component of caring for today's student and must assure that every member of the campus community recognizes the signs and symptoms of a mental illness and knows when and how to respond. In accomplishing this, the institution must evaluate its particular needs and implement an effective risk management program in consultation with clinicians and attorneys experienced in mental health law, college campus liability, risk management, and related areas of practice. Existing policies and procedures should be carefully reviewed by the administration and expert legal counsel. The administration and counsel should identify, compose, and implement any new procedures necessary to assure that confidentiality and accommodation rules are preserved at the same time mechanisms are in place to protect the students and campus from harm. The administration should conduct regular reviews of these procedures and actively assure that the procedures are implemented, and that the mechanism for implementing these is sufficient. The following are considerations in constructing a strategy for protecting an institution from liability:

- Clear directives and procedures must be established for assuring that any concerns raised about a student's mental health are addressed promptly and appropriately.
- The administration must recognize the counseling center's role in fulfilling the mission of the university to retain students and help the students meet their academic goals.
- The counseling center and the administration must understand the limits of the counseling center's abilities, establish clear policies to protect students whose needs exceed the resources of the campus counselors, and establish protocols for promptly meeting the students' and the community's needs in any way necessary. This must include clear policies for disclosure including contacting parents, warning those at risk, or making arrangements for hospitalization or other care, if indicated.
- The university must identify off-campus resources for addressing those in crises, including law enforcement, treatment providers, and hospitals, and must identify the circumstances where it is appropriate or necessary to avail itself of these resources.
- The counseling center and the administration should assure there is a well-established and regular communication between the various departments of the institution, including the deans' offices, residential services, the health center, any disciplinary board or entities, and campus security, that allows all who could potentially come in contact with a student in crisis to raise concerns. A mechanism should be in place for developing an action plan to protect the affected student. These interactions between departments must be consistent with confidentiality strictures.
- There must be ongoing efforts to educate the entire campus community to recognize those struggling with psychiatric issues, the resources available to assist such individuals, and how and when to connect these individuals with the assistance they need.
- Preventive and developmental activities, including outreach, consultation, personal growth issues, and education activities, must be dynamic and ongoing. Counseling centers should be a visible presence at orientation, freshman seminars, activity fairs and campus residences.
- Counseling centers must be adequately funded. The financing of mental health services should be analyzed and issue of access balanced with funding. For example, the institutions should assure that no student will be turned away if they are unable to pay for services. A careful evaluation may reveal that counseling centers are even able to generate revenue for much needed services through co-pays.
- The counseling center's ability to appropriately manage clinical needs should be evaluated regularly and adjustments made to assure the most effective delivery of services to students. The importance of meeting student needs by providing immediately accessible appointments, phone and internet consultations, evening and drop-in appointments should be considered and addressed. Some universities are experimenting with placing counselors in residences periodically in the evenings to encourage accessibility to services. Resources may be stretched by appropriate peer counseling programs, the use of graduate interns, group therapy, and developing self-help programs, such as pamphlets, videos, books, and access to Internet resources. Caseload management should be regularly evaluated and adjustments to staffing should be made when necessary. Diversity

in counselors' background, culture and training also should reflect the composition of the student body.

- The administration must consider and adopt a policy for when and how to identify and contact students at risk while preserving confidentiality.
- The administration should provide an opportunity for parents to approach the institution's counseling center about their children's mental health concerns both as incoming students with a history of mental health treatment or with concerns that develop in the course of their college years.
- The counseling center's role in "bailing out" students, as in making arrangements for deferring assignments or exams or facilitating a change in residence, must be delineated, and the procedure for doing so clearly established.
- Whether and when disciplinary proceedings should be initiated against a student experiencing psychiatric symptoms should be determined.
- Disclosure and confidentiality rules should be reviewed and understood by everyone concerned with the counseled individuals. Policies, including student staffing at campus counseling centers, should be developed and reviewed for potential breaches of confidentiality.
- All policies addressing disclosure should identify to whom disclosure may be made under relevant circumstances.
- The administration and the counseling center should set a policy and procedure for when and how to obtain "prospective" disclosures from students authorizing the institution to contact family. The policy (and the disclosure forms) should also address the circumstances that would allow the use of these disclosures.
- There should be disclosure policies for immediate/emergency disclosures, and less immediate but nonetheless pressing disclosures. For example, students showing signs of an eating disorder that gradually becomes critical may be identified and the issue effectively addressed if disclosed well before the student reaches a crisis.
- A policy should be developed for evaluating and documenting alternatives to disclosure.
- A policy should be developed addressing circumstances when disclosure will not be appropriate and the alternatives available under these circumstances.
- Appropriate disclosure forms should be drafted, reviewed by legal counsel, and made a part of the policies and procedures.
- Counseling staff should be thoroughly educated regarding legal and ethical issues and should have access to legal counsel when necessary. Administration should consult with legal counsel whenever a question arises regarding a student's behavior on campus.

"Universities and colleges must recognize the dramatic increase of those with psychiatric disorders on campus and their exposure to liability if they fail to act."

Conclusion

Universities and colleges must recognize the dramatic increase of those with psychiatric disorders on campus and their exposure to liability if they fail to act. It is essential that colleges and universities conduct a careful evaluation of their practices and policies, ideally in consultation with legal counsel who have expertise specific to these issues, to assure the protection of these students, the campus community, and the institution itself.

Endnotes

1. *The 2004 National Survey of Counseling Center Directors* (International Association of Counseling Services, Inc.). The survey included responses from 339 directors of college counseling centers, including 34 colleges and universities in New York State.
2. Bennett Kaplan & Maura Reed, *College Student Mental Health: Plan Designs, Utilization, Trends and Costs*, STUDENT HEALTH SPECTRUM, March 2004. Although some variations among campuses are noted, virtually all campuses reported a double-digit increase in utilization of psychological services over the ten-year reporting period.
3. The *Shin* case was settled in April 2006. The significance of the case is reflected in the fact that twenty-three universities and eight national higher education associations filed amicus briefs in the case. An administrator with the University of Maryland was quoted as saying the settlement "gives us more time in higher education to examine our policies . . . without the specter of legal fear that people have today." Marcella Bomardieri, *Parents Strike Settlement with MIT in Death of Daughter*, THE BOSTON GLOBE, April 4, 2006.
4. *The 2004 National Survey of Counseling Center Directors*, *supra* note 1.
5. There appears to be no formal analysis available of the causes of the increased incidence of mental illness on campus or of the actual number of students on campus with psychological issues. There has been a flurry of discussion in the press and profes-

sional journals and the information in this section is drawn from these sources: Suicide Prevention Resource Center, *Promoting Mental Health and Preventing Suicide in College and University Settings*, Newton, MA: Education Development Center (2004); Martha Anne Kitzrow, *The Mental Health Needs of Today's College Students: Challenges and Recommendations,* NASPA Journal, Vol. 41, No. 1 (Fall 2003); Peter Lake, Nancy Tribbensee, *The Emerging Crisis of College Student Suicide: Law and Policy,* Stetson Law Rev. Vol. XXXII (2002).

6. Kitzrow, *supra* note 4, 172–173.
7. Stephen Caulfield, Chickering's Fifth Leadership Forum: Depression on College Campus, Student Health Spectrum, Winter 2002. Summary of two forums with participation by a total of 22 colleges and universities. Quoting this characterization by a physician affiliated with the University of Virginia of the mission of counseling centers (as well as the student health service and the university) as the consensus of the participants.
8. Sara Schweitzer, *Case of the Hovering Parents: Universities Laying Ground Rules to Give Freshmen More Independence*, THE BOSTON GLOBE, August 20, 2005; Justin Pope, *Hovering Parents Problematic for Colleges*, THE ASSOCIATED PRESS, August 29, 2005. This article describes an incident where parents contacted the school's administration to convey their child's dissatisfaction with the sanitary facilities on a trip to China, Jean Marie Angelo, Privacy or Peril? University Business, January 2004.
9. Karen W. Arenson, *The Dorms May be Great, But How's the Counseling?*, N.Y. TIMES, October 26, 2004, at F1.
10. Section C(2) of the Accreditation Standards promulgated by the International Association of Counseling Services provides:

> The confidential nature of the counseling relationship must be consistent with professional ethical standards and with local, state, provincial and federal guidelines and state statutes. Information should be released only at the request or concurrence of a client who has full and informed knowledge of the nature of the information that is being released. Appropriate information is then to be released selectively and only to qualified recipients. Instances of statutory limits to confidentiality and other appropriate restrictions (e.g., policies related to observation, audio and video taping) need to be clearly articulated and implemented only after careful professional consideration.

11. 45 C.F.R. § 164.501.
12. *The 2000 National Survey of Counseling Center Directors*, Appendix A.
13. 29 U.S.C. § 794 and 34 C.F.R. Pt. 104.
14. *Eiseman v. State of New York*, 70 N.Y.2d 175 (1987) (doctrine of *in loco parentis* is basis for holding that "colleges today in general have no legal duty to shield their students from the dangerous activity of other students," holding university had no duty to shield students from an ex-felon who was admitted under a special program); *Ellis v. Mildred Elley School, Inc.*, 245 A.D.2d 994 (3d Dep't 1997) (rejecting that college stood *in loco parentis* to students, giving rise to a special duty); *Rothbard v. Colgate University*, 235 A.D.2d 675 (3d Dep't 1997); *Talbot v. New York Institute of Technology*, 225 A.D.2d 611 (2d Dep't 1996).
15. Peter F. Lake, *The Rise of Duty and the Fall of* In Loco Parentis *and Other Protective Tort Doctrines in Higher Education Law*, 64 Mo. L. Rev. 1, 6 (1999).
16. *Id.* at 23.
17. *Mullins v. Pine Manor College*, 389 Mass. 47 (1983).
18. *Knoll v. Board of Regents of the Univeristy of Nebraska*, 258 Neb. 1, 601 N.W.2d 757 (1999); *Furek v. University of Delaware*, 594 A.2d 506 (Del. 1991).
19. Dana Levine, *Institute Will Pay Kruegers $6M for Role in Death*, THE TECH, Vol. 120, No. 42, September 15, 2000 (reporting the settlement of a wrongful death claim filed by the parents of a student following a hazing incident at a fraternity on the campus of the Massachusetts Institute of Technology).
20. *Davidson v. University of North Carolina at Chapel Hill*, 142 N.C. App. 544 (2001) (university had a special relationship to injured cheerleader); *Kleinknecht v. Gettysburg College*, 989 F.2d 1360 (3d Cir. 1993) (there was a special relationship between college and student athlete who died due to a fatal heart arrhythmia during practice).
21. *Shin v. Massachusetts Institute of Technology*, 2005 Mass. Super. LEXIS 333 (2005); *Schieszler v. Ferrum College*, 236 F. Supp. 2d 602 (WD VA 2002).
22. Cases cited at *supra* note 11.
23. This narrative of the facts of the *Shin* case are drawn from the opinion of the Superior Court and from Deborah Sontag's article *Who Was Responsible for Elizabeth Shin?* THE NEW YORK TIMES SUNDAY MAGAZINE, April 28, 2002.
24. *The 2004 National Survey of Counseling Center Directors*, *supra* note 1.
25. *Id.*
26. Chronicle of Higher Education, Chronicle Forums, An Ounce of Prevention, August 5, 2005, et seq., *available at* http://chronicle.com/forums/colloquy/read.php?f=1&i=5393&t=5393, visited December 27, 2005.
27. Jason Feirman, *The New College Dropout*, PSYCHOLOGY TODAY, May/June 2005; Karen. W. Arenson, *Worried Colleges Step Up Efforts Over Suicide*, THE NEW YORK TIMES, December 3, 2004; Daniel Mcginn and Ron Depasquale, *Dealing With Depression*, NEWSWEEK KAPLAN COLLEGE GUIDE, 2004.

Lydia Hoffman Meunier is an associate attorney with Iseman, Cunningham, Riester & Hyde, LLP, a general practice law firm with many individual and institutional clients involved in the provision of health care, including health systems, hospitals, nursing homes, managed care organizations and physicians. Ms. Meunier has lectured on guardianship, advanced decision-making and Medicaid regulatory requirements. Ms. Meunier's practice includes extensive experience with the unique legal issues inherent in treating mental illness.

Carolyn Reinach Wolf is a partner in the firm of Reinach Wolf, Rothman & Stern which concentrates in the area of Mental Health/Health Care Law, providing legal representation and consultation to hospitals, skilled nursing facilities, outpatient centers, families, individuals, mental health practitioners and attorneys. She is the firm's founding partner and has lectured, counseled, provided advice and written extensively in these areas to mental health and health care medical and legal professionals.

The Brooklyn Mental Health Court

By Hon. Matthew J. D'Emic

Introduction

On October 1, 2002, in the packed ceremonial courtroom of Kings County Supreme Court, New York State Chief Administrative Judge Jonathan Lippman officiated at the opening of the Brooklyn Mental Health Court, the first such court in New York State. In attendance were service providers, defense attorneys, prosecutors, as well as Commissioner James Stone of the New York State Office of Mental Health. This attention was the culmination of months of careful planning led by Carol Fisler, J.D., of the Center for Court Innovation, the research and development partner of the Office of Court Administration.[1] Issues such as eligibility criteria, confidentiality, length of court mandate and the make-up of the clinical team were hammered out by court constituents. Now, after a six-month trial period, it was time for the court's work to officially begin.

The promise of such a court in New York State began with New York State Chief Judge Judith S. Kaye long before the planning started. A compassionate proponent of problem-solving justice, as evidenced by the availability of drug treatment and domestic violence courts to virtually every citizen of this state, Judge Kaye saw the need for the court system to find a better way to handle criminal cases involving defendants suffering from a mental illness. Judge Kaye recognized that often "the traditional approach yields unsatisfying results"[2] and commented that,

> When mental illness is a factor in lawlessness and that fact is ignored, the result can be an unproductive recycling of the perpetrator through the criminal justice system, with dire consequences to us all. The Brooklyn Mental Health Court offers judges the option of providing individuals with a mental illness the specialized attention they need, while protecting public safety.[3]

Kings County District Attorney Charles J. Hynes, an innovative and forward-looking prosecutor, also saw the need for a new way of looking at these cases, and commissioned his counsel, Anne Swern, to collaborate with the Office of Court Administration in establishing the first such court in Brooklyn.

Once the planning stage was over, the court hired a clinical director, Lucille Jackson, LCSW, another social worker and three case coordinators. Nancy Nedell, M.D., was also employed as the first consulting psychiatrist for the court.

The psychiatrist and social workers provide psychiatric and psycho-social reports to the court, including assessments of eligibility and dangerousness for each defendant referred to the court, and find appropriate placements for each defendant. The case coordinators insure frequent contact with the defendants and their service providers in order to facilitate compliance with any mandate of the court. This coordination is a lynchpin to the steady flow of information which aids the court in insuring public safety.

Once the court staff was in place, it needed to identify defendants appropriate for diversion into a mental health court. This challenge was met in two ways. First, all defendants returning fit to stand trial after a finding of incompetency came to the mental health court on the theory that a finding of mental incompetency may be a sign of a mental illness affecting criminal behavior.[4] Second, soon after the court opened, a memorandum from the Administrative Judge of the Second Judicial District was sent to all judges advising them of the availability of the court and outlining the criteria for making referrals. Assistant district attorneys and defense counsel were also advised of the existence of the court and their ability to refer cases. Brooklyn's two institutional indigent defense agencies, the Legal Aid Society and Brooklyn Defender Services, also provided a designated attorney to handle most of the agencies' mental health court cases.

With these referrals, the population of the court grew. The court, however, established as a non-violent felony mental health court, soon faced an unforseen challenge. Referrals of violent felonies and misdemeanors from criminal court were being made. The court's constituents decided that violent felonies would be accepted on a case-by-case basis, after a careful review of the underlying facts, and that misdemeanors would be accepted with a shortened mandate length of up to one year to reflect the maximum sentence allowable in the event of failure.[5]

Regardless of referral source or charge, the process of evaluation, acceptance and enrollment is the same. The court is voluntary: the district attorney and defendant must agree. Once that is established, defendants meeting the legal criteria are screened and evaluated. The evaluation process, as mentioned earlier, involves interviews of the defendant by a psychiatrist and a social worker to determine the presence of a disorder.

After the interviews are complete, written evaluations are given to the court, the assistant district attorney and defense counsel. If the defendant is found eligible for diversion into the mental health court, the court's clinical staff arranges the appropriate treatment, either residential or in the community, and the district attorney presents a plea offer.

If the treatment plan and the plea offer are acceptable to the defense, a plea is entered and the defendant is released to treatment. Until this point, the defendant may opt out of the mental health court and return to the original court part. Generally, the court mandate for a first felony offender runs for 12-18 months with sentencing deferred until completion. A successful defendant's case will generally be dismissed. A second felony offender's mandate runs for 18-24 months. If successful, the felony plea will be vacated and the defendant will be sentenced to probation on the misdemeanor plea. In cases involving violent felonies, the district attorney generally requires consent of the complainant before agreeing to a treatment plea. The period of court mandate is then a matter of negotiation between counsel.

Once a plea is taken the defendant begins treatment, and returns to court weekly for an update on his or her progress. As the defendant progresses, court appearances are less frequent (but never less than once a month); if a defendant regresses, more frequent appearances are required—sometimes every day. At the end of the mandate period, the defendant "graduates" from the court, and is sentenced as earlier mentioned, but continues to be enrolled in services that are arranged by the courts's clinical team, including medication management, psychotherapy, psycho-social rehabilitation, housing, and substance abuse treatment.

To be eligible for diversion into the mental health court, the defendant must suffer from a serious and persistent mental illness and there must be a nexus between the illness and the defendant's criminal behavior. Although the additional presence of a personality disorder or a substance addiction does not affect eligibility, generally speaking, the primary diagnosis must be an Axis I diagnosis, such as schizophrenia, schizoaffective disorder, bipolar disorder or major depression.[6]

One of the earliest cases referred to the court provides a clear example of its procedure. The defendant, accused of arson, was originally ruled out of the court by the assistant district attorney because of the violent nature of the charge.[7] However, after further discussion with defense counsel, the prosecutor looked carefully at the underlying facts. In so doing, it appeared that the defendant, a recent college graduate suffering his first psychotic episode of bipolar disorder, was arrested during a manic phase. Later depressed and in jail he attempted suicide. His cigarette dropped and started a fire resulting in the arson charge. The district attorney, after carefully reviewing the facts, agreed to eligibility and treatment. A plea was entered, a jail term was agreed to in the event of failure, as was dismissal in the event of success. This defendant, carefully monitored by the court and its clinical team, successfully completed his treatment mandate, graduated from the court and had his case dismissed.

Another example involved a defendant who faced many years in prison charged with consecutive counts of robbery in the second degree.[8] He was in college and again suffered his first psychotic break in his early twenties. This young man was diagnosed with schizophrenia and was apparently responding to command auditory hallucinations at the time of his crime. After 18 months of successful treatment, he was scheduled to graduate with a promised sentence of misdemeanor probation. His mother wrote to District Attorney Hynes and to the court seeking a dismissal. It was agreed that if he stayed with the court for an additional six months and did as well as in the previous 18 months, the case would be dismissed. He did so and the indictment was, indeed, dismissed. This young man is back in school, and will soon earn his degree.

This is not to say that all of the court's cases result in dismissals or sentences of probation. In fact, the court must always balance public safety against the needs of the defendant and his or her family. This, at times, requires the imposition of the agreed-upon sentence.

Currently, there are over 100 mental health courts operating around the country. Despite their proliferation, such courts are not without critics. Some argue that problem-solving courts in general are too far removed from the judiciary's traditional role, wrongly blur the line between advocacy and impartiality, and do

not work as well as advocates claim.[9] Others argue that such courts chip away at the adversarial system, our centuries-old safeguard of rights.[10] Some mental health advocates argue that such courts "criminalize mental illness and coerce treatment where criminal behavior is caused by mental illness,"[11] and that "they risk further criminalizing people with mental illnesses and fragmenting the mental health and criminal justice systems."[12] Others fear that mental health courts will ultimately be ineffective because of the lack of mental health resources.[13] In contrast, the National Alliance on Mental Illness (NAMI), a nationwide support and advocacy group, views mental health courts as an effective strategy to reduce unnecessary incarceration of mentally ill offenders.[14]

Given the brief history of mental health courts, including the Brooklyn Mental Health Court, it is much too soon to herald their success or to anticipate their failure. One thing is certain, however. Prior to these courts, judges, defense attorneys and prosecutors had two choices when faced with mentally ill defendants: trial or plea. Mental health courts offer a third option: treatment as an alternative to incarceration with proper safeguards for public safety. Although public policy cannot be based on anecdotal evidence, early statistics are encouraging.

To date, the Brooklyn Mental Health Court has received nearly 500 referrals. It has graduated over 80 and sentenced about 12. There are currently over 100 participants and about 80% are in compliance with their mandate. Other courts have met with similar success.[15]

Since the start of this Brooklyn experiment, Deputy Administrative Judge Judy Harris Kluger[16] has taken the lead in establishing additional mental health courts in New York State. Courts in Rochester, Buffalo, Niagara, and the Bronx are well established. Westchester and Queens County mental health courts began operating this year with more such courts in the planning stage.

In each of these counties, as in Brooklyn, the hope is the establishment of a unique interaction between the criminal justice system and the mental health care system focusing on the need for thoughtful approaches and the willingness of the legal and mental health care communities to support them. Ultimately, mental health courts will be judged on the success of this collaboration in reducing recidivism, helping offenders adhere to treatment and in these ways, promoting public safety.

Endnotes

1. CCI was founded as a public/private partnership between the NYS Unified Court System and the Fund for the City of New York. More information can be found on its website: www.courtinnovatin.org.
2. "Therapeutic Justice in Alaska's Courts" 19 Alaska L. Rev. 1.
3. N.Y.S. Office of Mental Health release 11/25/02.
4. CPL art. 730.
5. Pleas on misdemeanor cases are done through Superior Court informations to satisfy jurisdiction limitation set forth in CPL §§ 10.20, 10.30.
6. Axis I is a designation found in the Diagnostic & Statistical Manual 4.
7. Penal Law art. 160.
8. Penal Law art. 150.
9. *See, e.g.*, Hoffman, *The Drug Court Scandal*, No. Car. L. R., Vol. 78, No. 5, p. 1480 (June, 2000).
10. *See, e.g.*, Eator and Kaufman, "Judges Turn Therapist in Problem-Solving Court," NY Times, April 26, 2005 (p. 1).
11. Denkla and Berman, *Rethinking the Revolving Door—A Look at Mental Illness in the Courts* (NY Center for Court Innovation, 2001).
12. www.nmha.org/position/mentalhealthcourts.cfm.
13. Barr, *Mental Health Courts: An Advocate's Perspective*, (Urban Justice Center, 2001).
14. NAMI, "Support for Mental Health Courts."
15. *Id.*
16. Judge Judy Harris Kluger is the Deputy Chief Administrative Judge for Court Operations and Planning in New York State. She is responsible for court reform, restructuring projects and specialized courts.

Hon. Matthew J. D'Emic was appointed to the Court of Claims and is assigned to the Kings County Supreme Court where he presides over the Brooklyn Domestic Violence Court and Brooklyn Mental Health Court. Justice D'Emic is active in several organizations concerned with criminal justice issues in the areas of domestic violence and mental health, and lectures frequently on those topics.

Special Needs Trusts to Benefit the Mentally Ill Client or Family Member

By Marcia J. Boyd and J. David Seay

Introduction

A special or supplemental needs trust (SNT) is an estate planning and living trust tool for persons with disabilities, who receive or may in the future receive either Medicaid or Supplemental Security Income (SSI), or both. The SNT, authorized by both state and federal law,[1] provides funds for goods and services not covered by Medicaid and/or SSI benefits. The SNT is an important planning tool because it provides family or friends with a method to provide financial support to loved ones with disabilities, while also protecting the trust beneficiaries from losing their eligibility for Medicaid[2] and/or SSI.[3]

Using the Special Needs Trust for the mentally ill client or family member raises some questions unique to those with "severe and persistent mental illness." The SNT provides some crucial planning choices for this client and it is important the practitioner recognize these choices as possibly relevant whenever meeting ANY client for the first time.

Practitioners should also be aware of other resources in the community, such as the nearest affiliate of the National Alliance on Mental Illness (NAMI) as well as NAMI New York State, that can help clients with mental illness or clients with family members with mental illness better understand the causes, diagnosis and treatments of the various brain disorders that are collectively called mental illness. To find contact information for such affiliates and to obtain additional information in New York, clients and practitioners can visit the web site of NAMI New York State (NAMI-NYS) at http://www.naminys.org and click on the "affiliates" section or call the statewide toll-free help line at 800-950 FACT (3228) during normal business hours. A wealth of information on mental illness is also available on the national NAMI organization's web site, at www.nami.org.

Threshold Problem—How to Identify the Client

Due to the widespread perception of the stigma of mental illness the client often does not tell the lawyer that a family member is disabled due to one of the severe mental illness conditions, including bipolar disorder, schizophrenia, psychosis, major or clinical depression, and other diagnoses. The best practice is to ask every client if they have a family member with any disability and then to wait for a response. The response may not be that their child has a mental illness, but instead, after a long pause, that one or other family member has "some problems." The response may also be very hesitant and vague. Follow-up questions can include some of the following: Does the person work? Receive any sort of disability benefits? Receive any type of treatment? Ever been hospitalized? What sort of condition? How long has the condition been a problem? Where does the person live? Such follow-up questions can help the lawyer determine if use of the Special Needs Trust may be an option to present.

The client of course should be reminded of the nearly absolute confidentiality afforded by the attorney-client privilege and that the practitioner can better assist the client when all the relevant information and facts are disclosed and known, including the fact that the proposed SNT beneficiary has been diagnosed with a mental illness. Because the advisor may not meet directly with the disabled person, it is important to determine if "the client," for representation purposes, is the family member in the lawyer's office or the disabled person. In this article the term "client" is used in a more general sense without addressing that specific issue.

If the family or disabled person is referred by a mental health agency or related referral source, the threshold question of recognizing the client as one who may benefit from such planning does not occur. Then it can be very helpful for the lawyer to indicate an understanding of mental illness, ask about a diagnosis and treatment plan, and inquire as to health services or agencies providing support services.

The concept of the special needs trust or the existence of a disabled family member may never be mentioned if these questions are not part of the practitioner's ROUTINE initial interview. These conversations often occur in the context of estate planning or Medicaid planning. It is vital to ask such questions because otherwise the person with a disability could be adversely affected by the plan or may not benefit from some options available to them.

For example: Mother (M) is going into a nursing home. For many years adult son (A) with a mental ill-

ness has lived with mother in the mother's house. Another child of M comes to the attorney for advice concerning Medicaid planning, preparation of a power of attorney, estate planning, or some other question unrelated to A's needs. Unless the practitioner finds out A exists and that A is disabled, the following planning opportunities cannot be explored:

1. Under current Medicaid rules the house can be transferred to A (or to A's SNT) with no adverse impact on M's Medicaid eligibility.
2. M can transfer some of her assets, savings or resources to a Special Needs Trust for the benefit of A, without any transfer penalty being imposed on M, and thus no effect on M's Medicaid eligibility.
3. Such a transfer, if properly made to an SNT, will not adversely affect A's continued receipt of Medicaid and/or SSI.
4. It may be important for A to be connected to more support services, intensive case management, or other help, so A's daily life continues without unnecessary adverse impact, after M's move to a nursing home or assisted living, or M's death.

For many people with severe and persistent mental illness, full-time employment is not a viable option. As a result, many of these individuals rely on the two Social Security programs, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). In New York a person receiving SSI will "automatically" receive Medicaid. For the mentally ill, keeping Medicaid has to be a primary goal, because without Medicaid the person could not afford their medications or treatment.

Effective January 1, 2006, persons who were eligible for both Medicare and Medicaid ("dual eligibles") had their primary prescription drug coverage shift from Medicaid to the new Medicare Part D drug program. Such individuals were automatically enrolled in a randomly selected plan from among the various plans offered in New York State. They may change plans at any time. However, there are co-payments required under Medicare that were not required under Medicaid. Thus these dually eligible beneficiaries will actually see their own out-of-pocket costs increase under the new plan, thus perhaps increasing or exacerbating their need for an SNT. A full examination of the intricacies and complexities of these issues is not the intended subject of this article.

Both SSI and Medicaid are "needs based" programs, meaning that to qualify individuals must establish their income and resources do not exceed program limits. For example, a person with savings of more than $2,000 is not eligible for SSI or the related Medicaid benefits. A person with a monthly income of more than $692 (2006 amount) is subject to a Medicaid "spend-down"—whereby income in excess of $692 must be spent each month on medical expenses (as defined for this purpose by Medicaid) before Medicaid will cover remaining monthly expenses.

Some Examples—When to Use the Special Needs Trust

The person who becomes disabled after working for a few years, having thus accumulated a Social Security earnings history, would receive monthly SSDI benefits based on their earnings history, similar to calculations for retirement benefits. This person would also become eligible for Medicare benefits after the 24-month waiting period. These Medicare benefits are the same as those available to retired persons. But if the mentally ill person has high medication and treatment costs, most of which are not covered by Medicare, they will have to "spend-down" their disability income, in excess of $692/month, on "medical needs" as defined by Medicaid, before Medicaid will pick up any of these costs. *(NOTE: discussion of the impact of Medicare Part D medication coverage is not within the scope of this article).*

In New York State, if the disabled person received SSDI less than $692 per month due to their limited work history, he or she will also receive SSI in an amount to bring total income up to the $692 threshold. With the SSI the person also becomes automatically eligible for and will start to receive Medicaid. After the Medicare eligibility waiting period of 24 months, the person will also receive Medicare. Thus one person may receive benefits from FOUR programs: SSDI and Medicare, and SSI and Medicaid.

The complexity of understanding and successfully accessing multiple benefit programs is of particular concern for persons with serious mental illness and their families. Because of this complexity and difficulty in navigating these programs and benefits, family members of persons with mental illness and their advocates need to be aware of the eligibility and application rules and procedures of these programs. If the disabled person receives services from an agency with a staff expert in these programs, that may be a valuable source of guidance to the intricacies of these programs, including the myriad work rules. Practitioners are often in a

unique position to facilitate this educational process or referral to appropriate support services and lay advocates. Such education and understanding can help to maximize a mentally ill family member's benefits (or the mentally ill person may be the direct client) while at the same time helping the client structure an estate plan or SNT with the same objectives.

The following examples are not hypotheticals and include many of the problems the practitioner may encounter and needs to be able to recognize:

EXAMPLE 1—B is 45 years old. About 10 years ago she was diagnosed with anxiety disorder, bipolar and post traumatic stress disorder. Before these conditions disabled her, B worked for several years as a teacher. During her employment she saved about $50,000 in retirement funds which were rolled over into an IRA when she became disabled. During the past few years she has accumulated about $40,000 in medical bills because the medical insurance provided by her former employer covers only one-half of costs when she is hospitalized in the psychiatric center, which occurs about once a year. She has been able to pay for her medications because she found drug company subsidy programs to provide her medications at reduced cost and she pays the balance from her SSDI income.

She now receives SSDI of about $1,400 per month and has monthly medical costs (including medications) of about $600 per month, in addition to the back bills. This leaves her with only about $800 for all her living expenses, although, without her disproportionately high medical costs, her income would be enough to provide her with an acceptable standard of living in her western New York rural community.

The large teaching hospital where she was twice hospitalized referred her $7,000 bill to a collection agency which is aggressively pursuing payment from her. This unpaid hospital bill raises several interesting issues not within the scope of this article and is included because it is a common problem.

EXAMPLE 2—C is now 32 years old. His only income is SSI of $692 per month. He also receives a housing subsidy and food stamps. Recently C learned he will inherit $55,000 from an uncle in California. If he took the inheritance directly he would lose all his benefits. He calculates he would use up the entire inheritance within 1 or 2 years, primarily due to his medical expenses.

There is another even more critical reason C and his intensive case manager are very concerned he would lose his Medicaid benefits. Because his services are through Medicaid-funded programs, if he lost his Medicaid coverage, he might not be able to stay in the same treatment programs, and he would have to find new therapists. Such a change would probably lead to a recurrence of his more serious symptoms and be a serious setback to his gradual improvement.

He is also very concerned, and perhaps even more worried, because if he receives the $55,000 inheritance, he will lose his SSI benefits. It took more than 2 years from date of initial application for C to be determined eligible for SSI, and he was successful only after employing an attorney experienced in obtaining disability benefits for mentally ill persons, who represented C through the hearing stage before C was finally found eligible. The thought of having to reapply for SSI has triggered his anxiety disorders and may lead to his rehospitalization.

EXAMPLE 3—D is 28 years old and part of an intensive case management program. He receives SSDI of $850 per month based on his deceased parent's Social Security account. To meet the Medicaid "spend-down" requirements he must spend about $160 per month on medical costs before he can receive Medicaid, which pays for his intensive treatment program and his medications. He heard he could benefit from the $160 each month if it goes into an "income-only" Special Needs Trust. His case manager referred him to a lawyer familiar with Special Needs Trusts for more information.

EXAMPLE 4—H and W have three children. Two are married with children and financially secure. The third child, T, age 35, does not work and seems to have some "problems." Upon further inquiry the lawyer realized the "problem" is in fact a serious and persistent mental illness which prevents T from working, living independently or being able to manage her own finances. The other children do not associate with T because of her behavior issues and noncompliance with treatment and medication recommendations the family thinks have been offered to T. The parents, H and W, wish to provide for T in their wills but do not want to leave any inheritance directly to her because she cannot manage money, especially if in what has been described to them as her "manic" phases. None of the other children can agree to be the trustee of the SNT due to the adverse impact on their own families from contact with the ill family member, who does not respect their boundaries.

EXAMPLE 5—G is 55 years old, has a law degree, and was able to work for a year or two after law school graduation. G's problems with paranoia, bipolar disorder and other conditions then worsened until she

returned home to live with her father (F) who subsidized her and provided support with daily living. When F died G was not receiving any services, and was not receiving any mental health treatment. The attorney handling F's substantial estate did not realize that G was disabled because she never told him she was and presented herself as a self-sufficient person, although she had been receiving SSDI of about $550 for a few years and was receiving Medicare. G received her inheritance outright and started to use it to augment her SSDI (her only income) and to pay for her medical needs, which increased greatly due to the loss of her father.

F's will did not include an SNT for G for several reasons: the will was over 15 years old; F did not and never would have told his attorney about G's special needs due to stigma-related concerns; the lawyer never asked the questions to find out about G's special needs; although F himself was a lawyer he had never heard of an SNT; and, most germane to this article, the family did not ask the estate lawyer about an SNT because none of them had ever heard of one, and they—including the sibling executor—did not view G's situation as that of a disabled person but rather of a person with significant problems who was too dependent on F and had "to learn to stand on her own two feet" as had all of F's other children. In addition, the local lawyer in the rural county where F lived and who had worked with F and long advised the family, ***had never heard of a special needs trust*** until contacted by the lawyer later retained by G to set up the SNT.

After meeting with three lawyers, the last one mentioned the option of the SNT. By this time G had used part of the inheritance and had only a portion left to fund the SNT, although she could have sheltered the entire inheritance if the estate attorney had identified the beneficiary as eligible for one. Without the SNT she would have had to use almost all her money before she could be eligible for either SSI to augment the SSDI or Medicaid to cover all her medical costs not covered by Medicare.

How the Special Needs Trust Benefits the Mentally Ill Beneficiary

The SNT is especially useful for the person with serious and persistent mental illness in five primary applications:

1. Income-Only (Self-Settled)[4]
2. Self-Settled with Disabled Person's Own Savings or IRA Account or Other Resources[5]
3. Testamentary—In the Will of a Parent, Grandparent or Other Person[6]
4. Living or *Inter Vivos* Trust Set Up by a "Third Party" (parent, grandparent, sibling, friend, other) for the Benefit of the Disabled Person, Using "Third Party's" Funds[7]
5. Court Established—Based on Construction Proceeding of Will Leaving Funds to a Disabled Person, but Not in the Form of an SNT.

If any of these versions of the SNT is properly implemented, the beneficiary can receive the benefit of the SNT funds AND continue to receive SSI and/or Medicaid. The government benefit eligibility is not affected provided the trustee complies with certain restrictions applicable to use of SNT funds—no payments directly to the beneficiary, and no payments for needs covered by the government benefits the beneficiary receives.[8] Payments may be made only to a third party, not to the beneficiary directly. And the SNT cannot be used to provide needs covered by the benefits received. This is defined as "food and shelter" if the beneficiary receives SSI, and as "medical expenses covered by Medicaid" if the beneficiary receives Medicaid. But special rules may apply if the beneficiary's rent is more than one-third of the SSI benefit[9] and in some circumstances the SSI grant may be reduced by one-third, not stopped completely.[10] Note that a beneficiary receiving Medicaid does not necessarily have to also receive SSI, even if also eligible for SSI.

If a person with disabilities does not and WILL NOT IN THE FUTURE need or receive Medicaid and/or SSI, the SNT should not be used. However, because the course of severe and persistent mental illness is often difficult to predict, and may be lifelong, it is often wise to set up the SNT as part of an estate plan in the event it will be applicable sometime in the future, when the parent or other settlor dies. For example, a beneficiary may not receive SSI and/or Medicaid while living with a parent, but will need one or both after death of the caretaker parent.

While in some respects, somewhat different criteria apply to a third-party SNT than to a self-settled SNT, as a general rule in New York State, similar although not identical rules apply to both. In general, requirements to establish a valid SNT also must be consistent with Medicaid and SSI eligibility requirements. If the trust meets the statutory criteria, then the beneficiary, who is eligible for and/or receives SSI and/or Medicaid, can also benefit from payments from the SNT. It is essential that trust distributions are made only for certain purposes as discussed above and payments may be made

only to a third party *on behalf of* or *for the benefit of* the beneficiary, *not directly* to the trust beneficiary.

Benefits received from the SNT and assets transferred in the SNT are not considered "available resources" when determining eligibility for Medicaid or SSI. Nor is income directed into an "income-only" SNT counted as "income" when determining eligibility for Medicaid or SSI. Possible impact from the recently enacted Deficit Reduction Act is not within the scope of this article, but the SNT does not seem to be directly affected.

If properly drafted and authorized by the local Medicaid attorney, the beneficiary who receives Medicaid and/or SSI can benefit from payments from the SNT in addition to receiving Medicaid and/or SSI. The SNT pays for goods and services for the beneficiary that are not provided by the government benefits received by the beneficiary. For example, under federal law decrees that "food and shelter" are provided by SSI benefits, so, in general, the SNT may not be used to pay for food or shelter for the beneficiary. Some exceptions for shelter payments paid from the trust are not within the scope of this article.

It is vital that the trustee observes the basic rule that ***any payments from the SNT must be paid to third parties*** on behalf of the beneficiary, and ***not directly to the recipient/beneficiary.*** To summarize, the trustee may use SNT funds to make payments to third-party providers on behalf of the trust beneficiary for all goods and services except for those medical services covered by Medicaid, and for an SSI recipient, except for food and shelter.

Types of Special Needs Trusts

In general, the SNT is an irrevocable trust, established and funded by a "third party" on behalf of an individual under the age of 65; or funded by the disabled person him- or herself as a "self-settled" trust. The third party trust can be in a will to be funded upon death of the donor, or be a stand-alone trust funded by the donor while still living, or some combination of these. The self-settled trust is either a stand-alone trust or can be part of a pooled trust. The third party can also fund an account in a pooled trust, either during the donor's lifetime or upon death by will. A limited exception to the "under-65" rule is discussed below. There is also some use of income-only pooled trusts for those over 65, mostly in the New York City area. In certain situations, a will can include an SNT for a beneficiary over the age of 65. Also a court can establish a special needs trust for a personal injury or malpractice award. The last three examples are beyond the scope of this article.

The New York State statute includes specific language to use in the third-party SNT. It is prudent to use the statutory language as a beginning for all types of special needs trusts, and also to include other specific language from other sources, and tailored to the type of SNT being drafted. Other general considerations include obtaining a tax ID number; filing annual fiduciary income tax returns; complying with any reporting requirements of Medicaid, the court or others; advising trustees of their general fiduciary duties and the special rules for SNTs; fully informing all parties (including the trustee, settler, and self-settled donor) concerning trustee commissions; coordination of establishing the SNT and receipt of the funds to avoid overpayment issues with relevant government agencies; if the beneficiary receives or will apply for SSI, informing the Social Security Administration of the existence and funding of the SNT, and advocating with SSA if the client's worker is not familiar with the concept of the SNT; and coordination with the case manager if the client needs that assistance to successfully complete this very complicated and often frustrating process.

Self-Settled Trusts

Persons with severe and persistent mental illness, under the age of 65 (including a person under 18 by their parent or guardian), who meet the criteria for "disabled" may use their own income or savings to fund their SNT. They may have accumulated savings, retirement accounts, or other assets. However, as in example "1" herein, medication and those hospital costs and therapy not covered by insurance could quickly exhaust these savings. By transferring their assets to a self-settled SNT, persons with mental illness who meet Medicaid's disability criteria, if not already determined disabled by the Social Security Administration, will probably then qualify for Medicaid (and possibly also SSI and/or SSDI once SSA makes a favorable determination) to pay for their medical care, while the trustee uses the SNT to pay for some of their other expenses not covered by basic SSI of $692 per month. Examples of expenses often paid by the SNT include cable TV, high-speed Internet access, treatment not covered by Medicaid, tickets to social events, a computer, furniture, and car expenses. Thus the SNT preserves the disabled person's assets and uses their own assets for their own benefit, while basic needs are provided by government benefits.

The law requires a third party—parent, grandparent, guardian or court—to act as "settlor" of the SNT.[11] If the beneficiary's parents or grandparents—or any one of them—is living and willing to sign the SNT, they may sign the trust as "settlor." They are not funding the trust and may not even be the trustee. But their signature is required to "set up" the trust. If a parent or grandparent is not available to sign the SNT, and if the person does not have a guardian and does not need a guardian because they do not lack capacity, a court can be petitioned to establish the trust. Procedurally, consent and approval of the SNT by the appropriate social services attorney is filed with the court with the petition. Such a trust is "self-settled" in the sense that it is funded with the disabled person's own funds—savings and/or income, and, in the case of a proposed beneficiary with mental capacity, usually with the consent of the beneficiary.

A self-settled trust MUST INCLUDE a payback provision so any funds remaining in the SNT at the death of the beneficiary are first used to reimburse Medicaid for benefits paid. If the trust is funded by a third party—such as a parent or grandparent or friend—then the payback requirement is not included in the SNT.

Third-Party SNTs

The most common implementation of the "third-party supplemental needs trust" is by parents or grandparents including an SNT as part of their Wills. This type of SNT is funded only upon the death of the parent or grandparent (or friend or other person). This testamentary SNT is an excellent estate-planning tool to benefit persons with severe mental illness. As in example "2" herein, if the person with a mental illness ("B") were to receive the bequest or inherited gift outright, B would most likely no longer qualify for SSI or Medicaid and be forced to spend all of the inheritance for daily expenses and medical costs before being able to reapply for the benefit programs. By using the SNT as part of the estate plan, usually as a provision within the Will, then B can benefit from the inheritance over a long period of time.

As a third-party trust, the testamentary trust is not subject to the payback rules. Consequently the donor can state in the Will the persons or charity to whom the remainder funds are distributed at the death of the beneficiary. Some family members use this as a method to provide for a later donation to a mental health service agency providing services to their loved one or to support, education and advocacy organizations such as NAMI New York State.

Who Is the Trustee?

The trustee named in the SNT may be a family member, friend, social service not-for-profit agency, or a financial institution. The SNT usually also names a successor trustee or co-trustees, and may provide for naming a successor trustee by the named trustee. This provides flexibility in planning in the event the named trustee cannot continue in that role. When the beneficiary is disabled due to mental illness, it may be difficult to locate a family member or friend willing and qualified to act as trustee. Some social services agencies will not agree to act as trustee without a "gatekeeper" or active case management services due to difficult behavior by a particular beneficiary. Financial institutions often require a high minimum amount to agree to serve as trustee and again may require a case management agency or the like to act as intermediary with the beneficiary. This is a particular problem if the beneficiary exhibits difficult behavior patterns which could make the trustee's job very difficult.

The Pooled Trust

One solution to the problem of finding a suitable trustee is for local mental health social service agencies to establish pooled trusts.[12] The pooled trust is also ideal for trusts funded with smaller amounts which do not justify the cost of setting up an individual SNT.

Organizations such as the local NAMI or Mental Health Association affiliates, NAMI-NYS or the Mental Health Association in New York State (MHANYS) may be resources of information on whether such pooled trusts are made available by organizations in the client's or beneficiary's community. Except for the statewide NYSARC pooled trust, there are very few pooled trusts available outside the New York City area and perhaps none meeting the specialized case management needs of the mentally ill. Local organizations may be encouraged to set up such pooled trusts if aware of the benefits to their consumer population and if community members support and assist in the establishment of a pooled trust for their own area.

A pooled special needs trust can be managed by a not-for-profit organization that combines the contributions of many families into one "pooled" trust for multiple beneficiaries, thus providing common investment and management advantages. The pooled trust is an attractive option for families who have only a modest amount to put in the trust for their loved one. The not-for-profit organization also benefits by being able to pay for its services in administering the trust from the

trust and can also be designated to receive the balance in the account after the beneficiary's death.

A pooled trust allows parents or others to provide for the future needs of the named beneficiary even when they do not have enough money to justify the expense of establishing a separate trust. They pool their donation with funds held in the pooled trust for others. Funds remaining at the death of the trust beneficiary may be given to the administering organization, but are subject to some limitations if from a self-funded account. If the funds are self-funded, part of the remainder may be subject to Medicaid payback rules before the rest can be paid to remainderpersons, including the administering not-for-profit. If any portion is paid to a third party, other than to the administering agency, then the funds are subject to payback rules. However, if all the remainder funds go to the organization, the payback rules do not apply.

Another advantage of the pooled trust is that it can be self-funded by a person with a disability of any age, including over the age of 65. If the self-funder is over age 65, he or she will be subject to the Medicaid five-year "look-back" period for transfers to a trust.

Pooled trusts are underutilized. They can be highly beneficial for people with mental illnesses and as a long-term funding plan for not-for-profit organizations providing services to this population. As mentioned previously, there are a number of mental health organizations that may have information on the availability of such pooled trusts in particular areas or may be interested in establishing a pooled trust.

Self-Funded "Social Security" SNT

The SNT funded with a lump-sum retroactive payment from Social Security may be funded by a person of any age, and is not restricted to those under the age of 65. This beneficiary can establish their own SNT and the requirement that the SNT be set up by a "parent, grandparent, guardian or court" does not apply. In general, the lump-sum award and trust assets must first be used to repay benefits received while waiting for the disability determination. But future SSD benefits are not subject to self-settled payback requirements upon death of the beneficiary. The law permits Social Security beneficiaries of any age, including those over 65, to establish and fund their own SNT with the lump-sum award.[13]

The Insurance Problem

New York is one of the few states in which the law does not require insurance companies to cover mental illness treatment the same as treatment for other conditions. For example, in New York State, a person presenting with personality changes and headaches who was referred for mental health treatment, under a typical policy with the most generous benefits would have coverage limited to 20 doctor visits a year, a co-pay of one-half (e.g., for a visit to a psychiatrist reimbursed at rate of $120, patient pays co-pay of $60 and insurer pays $60). If the same person is later rediagnosed with a brain tumor, then all doctor visits and other treatment are fully covered, with the nominal co-pays applicable to most doctor visits and only medical criteria—not an arbitrary and fixed number—used to limit the number of hospital days and number/type of doctor visits.

If this person required hospitalization for what had been diagnosed as a brain tumor, the entire stay would be covered. If the diagnosis were one of the mental illnesses, virtually every policy in New York State would cover a maximum of 30 days in the hospital. Thus the person with a persistent and serious mental illness, who lives in New York State, and who has good health insurance, will still need Medicaid, unless that person can afford to pay out of pocket for one-half of all doctor visits (or the entire cost if more than the 20 or so limit per year), any and all hospitalization more than 30 days, the probably uncovered 50% co-pay for hospitalization, and for medication co-pays.

A proposed statute, commonly referred to as "Timothy's Law" has been pending for several years in the New York State Legislature, and although it or similar versions are annually passed by the Assembly, the State Senate has yet to approve any comprehensive version of a parity law for the state, although a majority of the State Senators signed as sponsors of such a law in 2004.

Conclusion

If assets or income is used to fund the SNT, it becomes an important estate-planning and living trust tool to benefit persons with severe and persistent mental illness, especially those under age 65 who are eligible for Medicaid and/or SSI. With proper planning, the SNT can be incorporated into a will or used as a living trust to improve the quality of life for people with disabilities, without adversely affecting their government benefits. Practitioners should realize that SNT beneficiaries with serious mental illness may have more difficulty than the general population or client population in understanding their rights and benefits under the terms of these various SNT arrangements. Extra care should be taken in helping them (using a subjective standard), as well as their settlors, trustees, guardians,

case managers and family members to fully understand and make maximum use of their SNT.

Endnotes

1. 42 U.S.C. § 1396p(d)(4)(A), (C); EPTL § 7-1.12; Soc. Serv. Law § 366(2)(b)(2); 18 NYCRR § 360-4.5(B)(4).
2. 42 U.S.C. § 1396p(c)(20(B); HCFA State Medicaid Manual, Transmittal No. 64 § 3258.1(6); Soc. Serv. Law § 366(5)(d)(3)(ii)(D).
3. 42 U.S.C. § 1396p(d).
4. *In re Lynch*, 703 N.Y.S.2d 653 (Sur. Ct. 2000).
5. *See supra* note 2.
6. EPTL § 7-1.12; Soc. Serv. Law § 104(3).
7. *See supra* note 6.
8. 20 C.F.R. § 416.1123; EPTL 7-1.12(b)(3); 18 N.Y.C.R.R. § 360-4.5(b)(4).
9. *Ruppert v. Bowen*, 871 F.2d 1171 (2d Cir. 1989).
10. 20 C.F.R. § 416.1103(g).
11. 42 U.S.C. § 1396p(d)(4)(A).
12. 42 U.S.C. § 1396p(d)(4)(C)(i)-(iv); (C); Soc. Serv. Law § 366(2)(b)(2)(iii)(B).
13. EPTL 7-1.12(a)(5)(v).

Marcia J. Boyd is a private practitioner in Rochester, NY, and concentrates her practice for the elderly and disabled in the areas of Elder Law, Special Needs Trusts, and Estates and Trusts. Ms. Boyd is a member of the Executive Committee of the NYSBA Elder Law Section and is active with several community groups, including Rochester NAMI (National Alliance on Mental Illness), and the Monroe County Mental Health Coalition.

J. David Seay, Esq., is Executive Director of the National Alliance on Mental Illness of New York State (NAMI-NYS). He is also Co-Chair of the Mental Health Issues Committee of the New York State Bar Association's Health Law Section.

Fiscal Challenges to Outpatient Mental Health Clinics Operating in New York State

By Justin Frazer

Introduction

In recent years outpatient mental health clinics in New York State have been coping with considerable fiscal challenges. The increase in admitted Medicaid and Medicaid Managed Care patients (both adults and children) needing mental health services, especially in New York City, coupled with the State's policy of Medicaid Neutrality, challenges the solvency of mental health clinics since Medicaid rates (and the supplements attached)[1] are not sufficient to match the costs of operation.[2] Low Medicaid reimbursement rates together with other cost effecting variables, such as salary scales, the cost of "no-shows," the cost of supervision, the use of clinical psychologists and child psychiatrists in children's programs, etc., makes operating an outpatient mental health clinic in New York State very difficult.

According to a recent report on the current financial state of outpatient mental health clinics, the Coalition of Voluntary Mental Health Agencies writes:

> providers who have committed themselves to providing integrated quality care are closing or cutting back the volume of service at an alarming rate. In New York City, the most recent provider to cease provision of mental health services is one of the City's largest and longest serving provider of health and human services. Another historic provider of clinic services, one noted for the quality of its training and services has identified a five-year $18 million deficit associated with its clinic operations. That provider has closed several clinic programs and may close several more. A third provider has notified the New York State Office of Mental Health (OMH) that it will close a clinic satellite in a cost-cutting move designed to save $250,000 annually. In every case, consumers must switch from providers with whom they have developed a therapeutic relationship of trust, and some communities will be without mental health services at all. These examples are the tip of an iceberg of crisis.[3]

The fiscal viability for all New York State outpatient mental health clinics is threatened. However, for clinics designated Non-COPS the situation is even more dire. Unlike COPS agencies, Non-COPS receive only a small subsidized supplement on Medicaid sessions (as opposed to the sizeable subsidy paid to COPS agencies) and no supplement on Medicaid Managed Care sessions. Both COPS and Non-COPS agencies offer identical services and must comply with the same licensing requirements.[4] The rate disparity between Non-COPS and COPS providers for a single visit can be as much as $300.[5]

New York State should no longer ignore the financial crisis facing outpatient mental health clinics. Easily accessible and effective treatment for mentally ill, emotionally disturbed and "worried well" individuals and families is a necessary endeavor that improves the quality of life for all New Yorkers and saves the State tens of thousands of dollars for every consequently avoided incarceration, psychiatric hospitalization, incident of unemployment, etc. The New York State Mental Hygiene Task Force's Assemblyman Peter M. Rivera acknowledged that, owing to the importance of the continued solvency of mental health clinics in the State of New York, the current funding structure should be re-evaluated.[6] A new fee structure should be implemented where standardized fees per session are paid to clinics regardless of their designation. The creation of a standard rate is not a new concept in New York. Recently, the State established standard rates for alcohol and substance abuse providers. OMH should follow suite. A standardized fee will create a fair and rationalized funding system for all clinics where State funding would follow the patient instead of the provider.

The following is an operational and fiscal overview of New York State outpatient mental health clinics. The article is divided into six sections. The first two sections will explain the function and purpose of clinics within the State focusing on who the clinics serve and the treatment they offer. The following four sections will point out fiscal challenges to outpatient mental health clinics including the State's policy of Medicaid Neutrality and illustrate how those challenges affect the Medicaid rate and fee structure to outpatient mental health clinics. Finally, the conclusion will suggest that eliminating supplements to both COPS and Non-COPS designated clinics and adding this funding to the base standardized rate

of all freestanding clinics will not only serve to ameliorate the crisis in community clinic funding but also increase patient care and save significant Medicaid funding.

I. What Is an Outpatient Mental Health Clinic?

Community-based mental health outpatient clinics or clinic treatment programs, licensed as Article 31 programs (which also include clinic treatment programs serving children, partial hospitalization programs, Continuing Day Treatment (CDT) and intensive psychiatric rehabilitation programs), are regulated by the New York State Office of Mental Health (OMH) in accordance with the provisions of Part 551 of the State Mental Hygiene Regulations.[7] The scope and practice of Article 31 programs is expressly outlined in Parts 587 and 588.[8]

Outpatient mental health clinics provide low-cost, outpatient treatment to children and adults with diagnosed moderate and severe mental health problems usually in the form of scheduled 45-minute psychotherapy appointments. They are designed to reduce symptoms, improve functioning and provide ongoing support. Services allowed by regulatory authority are individual, couples, group and family psychotherapy, health screening and referral, medication therapy, medication education, symptom management and for those with longer-term illness, referral to a rehabilitation and recovery program. In addition, clinics may also provide case management services, crisis intervention, clinical support, family psycho-education and family treatment services.[9]

Mental health clinics are located within every county in the State and can be operated by a variety of types of providers, including community-based, freestanding, not-for-profit, hospital affiliated, state psychiatric hospital and local counties of mental health.

II. Who Do Clinics Serve?

Outpatient mental health clinics provide a variety of mental health services to insured and uninsured individuals. Many of the existing programs were established originally with the intent to specifically provide services to communities where mental health treatment was necessary to adjust to the effects of the deinstitutionalization of patients from in-patient psychiatric hospitals in the early 1970s. With the closing of in-patient psychiatric hospitals, communities had a need to provide mental health services and treatment to former patients who resided in the hospitals. Many clinics were also formed before the advent of Medicaid and were intended to serve clients who could not afford to get psychotherapy from the private sector. For most clinics, the majority of consumers come from poor, working-middle class or other underserved communities where English is not always the primary language. In New York City, for example, clinics are coping with a rapidly growing Hispanic population (both adult and children), which, according to the New York City Department of Health and Mental Hygiene exhibits the highest level of emotional distress (as compared to black and white New Yorkers).[10]

Although clinics endeavor to provide low-cost, easy access for mental health services, with culturally and linguistically competent therapists, these clinics are not only challenged by low Medicaid reimbursement rates but are also dealing with other cost variables resulting from increased demand for services, such as:

1. the rising number of uninsured and underinsured patients;
2. the costs associated with psychiatric services, licensing and credentials required;
3. the cost of supervision; and
4. the number of client "no-shows."

In New York City it is estimated that outpatient mental health clinics serve over 250,000 patients. The steady increase in consumer utilization is attributable to (a) the increasing adult populations needing services,[11] (b) the increasing poverty levels in some communities[12] and (c) the dramatic increase in child consumers due to these growing communities and their increases in poverty levels, as well as the upsurge in reported cases of Post Traumatic Stress disorder in the wake of 9/11.[13]

Treating children and providing linguistically and culturally competent psychotherapy and pharmacotherapy are areas of service delivery that have clearly been demonstrated to cost agencies more to provide. In order to contend with the increasing costs of operation, clinics have been forced to rely on creative and untraditional means to remain solvent, such as relying on philanthropic subsidies, fixing staff salaries, keeping salaries artificially low, increasing caseloads and operating with minimal support staff.

III. The Medicaid Neutrality Cap Limits Treatment to All Individuals

Despite the mounting populations of individuals needing mental health services (especially children), the State's policy of Medicaid Neutrality effectively limits clinics from treating the entire population in need of mental health therapy. Under Medicaid Neutrality, the State retains the option to cap the amount of Medicaid dollars for mental health services to particular programs in aggregate to the State. In this regard, if an outpatient clinic found that the community it serves has a substantial increase in Medicaid patients, the State may prohibit

that clinic from treating the entire population seeking therapy by limiting the amount of Medicaid dollars (i.e., Medicaid-eligible patients) that clinic can admit. The State also frequently refuses to issue additional licenses to open new clinics or satellite facilities to provide services to clearly demonstrated underserved communities.

Medicaid Neutrality arose in the 1990s as an understanding between OMH and the N.Y. State Division of the Budget (DOB), which in turn may have been responding to pressure on the Federal level. The arrangement permitted DOB to retain control of the Medicaid budget while the State undertook a policy to maximize the Federal contribution to mental health services by transferring programs to Medicaid funding. If program capacity increases were granted based solely on a demonstration of necessity, the State would be unable to restrict the program growth and the total Medicaid budget would increase. As it stands, Medicaid reimbursement is distributed as follows: 50% is funded by Federal sources; 25% comes from N.Y. State; and the remaining 25% is matched by the local government unit (county government).[14]

As a way to maintain control over Medicaid budgets, Medicaid Neutrality was put into effect to limit the State's share of Medicaid spending on mental health services. Although the cap is not explicitly stated in law or regulation, it is implemented in roundabout ways. The mental hygiene regulations in 14 N.Y.C.R.R. § 551.13 state that, "in reviewing outpatient projects, the Office of Mental Health shall consider . . . for Medicaid or local assistance, the impact, source, and availability of the State share of such funds."[15]

Medicaid Neutrality effectively caps the State's share of Medicaid spending without assessment of the needs of the community or the quality of programs. By upholding this policy at a time when individuals needing mental health treatment are increasing (which is coupled with a fee structure where Medicaid rates and supplements are below the cost of actual treatment, especially to Non-COPS clinics), the State is making it virtually impossible for outpatient mental health clinics to remain fiscally viable.

IV. Rates and Fees for Outpatient Clinics

Base Medicaid Fees

Outpatient mental health clinics are primarily funded through an intricate system of third-party insurance payers where Medicaid—and increasingly Medicaid Managed Care—is the most predominate payor since it is a policy of State government to use Medicaid dollars to replace State dollars for existing programs.[16] All clinics in greater New York City receive a base Medicaid fee of $71.94 per session.[17] For clinics in Upstate New York the base Medicaid rate is either $64.75 or $63.55 per session depending upon which county the clinic is located.[18] Non-Medicaid Managed Care fees, indemnity insurance reimbursement and a sliding fee-scale payment based on personal finances, round out the clinic revenue picture and are all generally lower than the base Medicaid fees.

Supplements to the Base Medicaid Rate

In 1991, the State enacted a policy to provide a Medicaid payment supplement of up to $83.20 to the base Medicaid fees[19] of Article 31 clinics participating in the Comprehensive Outpatient Program (COPS) to improve clinic services and access to seriously and persistently mentally ill (SPMI) adults and seriously emotionally disturbed (SED) children.[20] The COPS program was created to save State dollars and help provide better community services. At the start of the COPS program, the State required only outpatient clinics that were already receiving "deficit funding" through individual contracts with counties because they could not remain fiscally viable on patient care revenues alone, to become COPS clinics. Almost all clinics that were deficit funded became, overnight, what has come to be known as COPS clinics. Since then, the COPS supplement has increased steadily until today, where it is now up to $300 (at certain clinics) for each session in addition to the base Medicaid rate.

Outpatient clinics that did not already have a contract with the county were not allowed to become COPS providers in 1991, and they are not eligible to become COPS clinics today. A Non-COPS clinic may not become a COPS clinic even though it provides exactly the same services. As such, this historical distinction has resulted in clinics that provide an identical service, but have a significant difference in funding.[21]

Non-COPS Clinics

Non-COPS clinics receive the base Medicaid fee per visit.[22] In addition, since 2000, Non-COPS clinics were presented with the option to contract with OMH to receive a small 12.5% ($7.73) supplement to their base Medicaid fee for a specific amount of units per service per year as determined by the Commissioner (i.e., the threshold).[23] Any Medicaid supplemental dollars received by Non-COPS clinics in excess of the threshold are to be recovered by the State through the Non-COPS volume adjustment process.

Unlike COPS clinics, Non-COPS clinics are not eligible to receive their 2000 supplement on Medicaid Managed Care sessions. However, according to a study conducted by the Federation of Mental Health Centers Inc., fifteen (15) agencies demonstrated an overall average decrease of weekly Medicaid sessions by 1.64% or 6.27

sessions per week from 1998-1999 when compared to their current volume. In contrast, Medicaid Managed Care sessions have increased by 72.3% or 43.16 sessions per week in the current year when compared to 1998-1999. Since there is a very significant shift of volume to Medicaid Managed Care, the exclusion of Non-COPS clinics from receiving any supplement on Medicaid Managed Care sessions is substantial.

Medicaid Reimbursement for Mental Health Clinics

	Base Medicaid Rate (per session) *Based on clinics in Greater NY*	Supplement	Total Reimbursement (per session)
COPS	$71.94	$170.00[24]	$241.94
Non-COPS	$71.94	$7.73	$79.67

COPS and Non-COPS Clinics Provide the Same Service

Under the current fee structure for outpatient mental health clinics a Medicaid-eligible individual who visits a Non-COPS clinic for weekly therapy sessions will generate Medicaid revenues at a substantially lower amount than if that individual sought the identical treatment at a COPS clinic. Furthermore, a report by the New York State Commission on Quality of Care (CQC) in 1996 concluded that, notwithstanding the COPS supplement, Article 31 Non-deficit funded (Non-COPS) clinics were actually serving a higher percentage of seriously and persistently mentally ill (SPMI) adults and seriously emotionally disturbed (SED) children (47%) than COPS providers (42%) who were receiving these subsidy payments.[25] Currently, there are no indications of an increase in SPMI adults and SED children in COPS agencies or a decrease of these same consumers in Non-COPS agencies.[26] Without the COPS supplement, Non-COPS agencies are essentially treating the greatest amount of consumers, especially SPMI adults and SED children, for the least amount of State and Federal compensation.[27]

On December 8, 2003, John Rossland, Ph.D., President of the Federation of Mental Health Centers, Inc. which represents Article 31 clinics, and who is a member of the N.Y. State Assembly Mental Hygiene Task Force Resource Committee, wrote to Assembly Mental Health Committee Chairman Peter Rivera regarding COPS funding. Dr. Rossland summed up the situation as follows:

> The funding system in New York must become rational and equitable. There are major disparities with unequal funding for patient care. There should be patient funding, not program funding and the money in the mental health system needs to follow the patient, not the provider . . . This disparity in funding hurts all providers under Medicaid in New York State and may ultimately jeopardize all programs.

V. Standardized Fees Would Alleviate the Funding Crisis

A solution to the inequity in rates and fees that would also increase patient care without challenging Medicaid Neutrality is eliminating the COPS/Non-COPS funding structure and redistributing COPS subsidies as an increased standardized base rate for all Medicaid consumers. Under such a structure, a Medicaid-enrolled individual's treatment would be reimbursed with identical rates at all outpatient mental health clinics. A standardized fee structure would not only save Medicaid dollars but would also increase patient care.

Here is how standardized rates could work. Clinic A in New York City is a COPS clinic which receives a $170 supplement per Medicaid session. Clinic B is a Non-COPS clinic in New York City which receives $7.73 supplement per session. In 2004, Clinic A and B complete 10,000 sessions—8,000 are Medicaid. For the 8,000 sessions Clinic A and B are both reimbursed $575,520 (=$71.94 Medicaid base rate x 8,000 sessions). However, Clinic A also receives an additional $1,360,000 as its COPS supplement (=$170 COPS supplement x 8,000) while Clinic B is reimbursed on its Non-COPS supplement an additional $61,840 (=$7.73 Non-COPS supplement x 8,000). Under the current fee structure Medicaid reimbursement for each clinic completing the same number of sessions is:

Clinic A (COPS)
$1,935,520 (=$575,520 + $1,360,000)

Clinic B (NON-COPS)
$637,360 (=$575,520 + $61,840)

Clinic A (the COPS clinic) is reimbursed three times the amount of Clinic B (the Non-COPS clinic) even though each clinic is offering identical services. Furthermore, although Clinic A is reimbursed at a higher level than Clinic B, under Medicaid Neutrality the high reimbursement rate could potentially harm patients seeking treatment at Clinic A. If Clinic A were located in a community with a growing population of Medicaid-enrolled individuals needing mental health services, the State could refuse any further Medicaid reimbursement in order to curtail Medicaid spending to one particular clin-

ic. Community need does not supercede Medicaid Neutrality. In this situation patients are either refused treatment or are forced to travel to another clinic which for the poor or working class may be quite difficult or impossible.

If the State were to institute a standard rate, such as $120 per session in lieu of the COPS/Non-COPS supplement, then each clinic would be reimbursed $960,000 (=$120 x 8,000) and Medicaid reimbursement would not be so disproportionate to one clinic. Consequently, two phenomena would also result. First, the State would realize a savings (based on 16,000 Medicaid sessions) of $652,880 (= [$1,935,520 + $637,360] – [$120 x 16,000]) or 25% (= $652,880/ [$1,935,520 + $637,360]). Second, clinics located in communities where the population is growing could admit more patients without increasing the State's allotted share of Medicaid dollars (i.e., maintaining Medicaid Neutrality). Consequently, Clinic A could effectively earn as much, if not more, than what it earns under the current cost-based fee structure simply by treating more consumers.

A standardized rate for Medicaid consumers places the emphasis for funding on consumer choice instead of the provider's contracted relationship with the local government. The New York State Office of Alcohol and Substance Abuse Services (OASAS) has already implemented a standardized fee as a solution to their previously problematic cost-based fee structure. This concept is not new to New York State.

VI. Conclusion

Outpatient mental health clinics are facing a serious financial crisis. If the State continues its current fee structure, many clinics will have to close or limit operations. In a time where more individuals, especially children, are seeking mental health services, the State cannot afford to lose more clinics. The current fee structure coupled with Medicaid Neutrality essentially harms the patient. The State's share of Medicaid dollars could be effectively controlled and all individuals needing mental health services could be treated if the State were to follow the lead of OASAS and adopt a standardized fee for all Medicaid-eligible consumers.

Endnotes

1. See discussion on Medicaid supplements.
2. Between 1990 and 2003, the Consumer Price Index has increased 41% and non-hospital medical services costs (excluding drugs and equipment) have increased 67% in the same period (U.S. Centers for Disease Control and Prevention report, *Health United States 2004*). It is significant that clinic rates have only increased by 10% in this period.
3. *Crisis in Community Clinic Funding Threatens Mental Health Treatment Programs*, The Coalition of Voluntary Mental Health Agencies (p. 2).
4. See 2001 Regulation requiring the Non-COPS providers to officially enter a Memorandum of Understanding with the Office of Mental Health that they performed the same services as COPS clinics.
5. Since COPS clinics can receive a supplement on Medicaid and Medicaid Managed Care of up to $300 (explained in detail later).
6. *See Keeping Promises, Healing Lives: A Report on the Restructuring of the Mental Hygiene Delivery System*, N.Y. State Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities (p. 35–36)
7. *See* 14 N.Y.C.R.R. § 551.
8. *See* 14 N.Y.C.R.R. §§ 587, 588.
9. *See* 14 N.Y.C.R.R. § 587.8.
10. New York City Department of Health and Mental Hygiene, *Health Disparities in New York City,* p. 10 (2004).
11. *See* 2000 U.S. Census Report
12. *Id.*
13. Samantha Marshall, *Childhood Trauma Stuns Researchers,* Crain's N.Y. Business, July 5–11, 2004.
14. The policy consideration at the time the local match was mandated was that if local governments had a financial stake in services delivered, they would exercise their fiduciary responsibilities to ensure funds were expended appropriately and efficiently. Over the years, as Medicaid expenditures have increased, the burden on local governments, which rely primarily on property taxes for revenues, has stretched them to their financial limits.
15. *See* 14 N.Y.C.R.R. § 551.13.
16. *See Keeping Promises, Healing Lives: A Report on the Restructuring of the Mental Hygiene Delivery System*, N.Y. State Assembly Committee on Mental Health, Mental Retardation and Developmental Disabilities (p. 33).
17. *See* 14 N.Y.C.R.R. § 558.13, Base Medicaid Fee Reimbursement for Outpatient Programs.
18. *Id.*
19. The current $63.55 to $71.94 is described in the previous section.
20. *See* 14 N.Y.C.R.R. § 592.7(a)(1).
21. In 1999, Non-COPS clinics formally requested NYC Department of Health and Mental Hygiene to become COPS clinics and were denied.
22. *See* 14 N.Y.C.R.R. § 583.13.
23. *See* 14 N.Y.C.R.R. § 588.14.
24. The COPS Supplement can be as high as $300, but the average is $170 according to a source at OMH.
25. The NYS Commission on the Quality of Care for the Mentally Disabled, *Why Do Psychiatric Clinic Costs Vary by 1,030%?*, (1996), pp. 1, 4, 5, 15.
26. It is estimated that the current Non-COPS percentage of SPMI adults and SED children is significantly higher than the estimate provided in the 1996 report.
27. In 2000, the Non-COPS agencies received a supplement of up to $7.50 on Medicaid visits based on this Commission on Quality Care report.

Justin Frazer is Regulatory and Policy Advisor for the Federation of Mental Health Centers, Inc.

EDITOR'S SELECTED COURT DECISION

***In the Matter of Visiting Nurse Service of New York Home Care*, Respondent *v. New York State Department of Health, et al.*, Appellants.**

5 N.Y.3d 499, 806 N.Y.S. 2d 465 (November 17, 2005)

Victor Paladino, for appellants.

James W. Lytle, for respondent.

Mercy Hospital of Buffalo, et al.; Home Care Association of New York State, Inc., *amici curiae*.

GRAFFEO, J.:

The issue in this case is whether a home health care provider is entitled to notice and an opportunity to be heard before the State acts to recover Medicaid payments it claims were improperly paid to the provider. Based on regulations promulgated by the New York State Department of Health, we agree with the courts below that a hearing must be held regarding recoupment of the Medicaid funds in dispute.

Medicare and Medicaid are two primary sources of payment for home health care services rendered by providers such as petitioner Visiting Nurse Service of New York Home Care (VNS). There are, however, significant differences between these government-sponsored programs. Medicare is a federal program that provides reimbursement for the medical expenses of persons eligible for Social Security benefits; it is administered exclusively by the United States Department of Health and Human Services (*see* title XVIII of the Social Security Act [42 U.S.C. §§ 1395 *et seq.*]). Providers submit claims to the federal agency's fiscal intermediary for evaluation (*see* 42 C.F.R. 424.32[a][1]) and this assessment process uses criteria established by federal law and regulations. Providers can pursue an administrative appeal procedure for rejected claims (*see e.g.,* 42 C.F.R. 405.710 *et seq.*; 42 C.F.R. 405.724).

The Medicaid program pays for medical and health services supplied to individuals who fall below a certain income threshold (*see* title XIX of the Social Security Act [42 U.S.C. §§ 1396 *et seq.*]). Unlike Medicare, which is fully funded by the federal government, in New York, the State and its counties contribute to the payment of Medicaid-eligible claims (*see* 42 U.S.C. § 1396a[a][2]; §§ 1396b, 1396d[b]). Because of this joint participation, in addition to providing Medicaid coverage for an array of medical and health services specified under federal law, a State may establish its own eligibility criteria, expand the types of services that qualify for coverage and set rates for reimbursement (*see generally* 42 U.S.C. §§ 1396d[a], 1396o[c][1], [d]; § 1396r-1[a]; 42 C.F.R. 440.225, 460.2[b]).

Health care providers file Medicaid reimbursement claims with the New York State Department of Health (DOH) in accordance with state law and regulations (*see* Public Health Law § 201[1][v]; Social Services Law § 363-a[1]). Medicaid is referred to as a "'payor of last resort'" under federal law because other potential sources of payment, such as Medicare, must be exhausted before claims are paid by Medicaid (*Gold v. United Health Servs. Hosps.*, 95 N.Y.2d 683, 690–691 [2001], quoting S Rep No. 146, 99th Cong., 2d Sess. 1, 312, reprinted in 1986 U.S. Code Cong. & Admin. News 42, 279; *see* 42 U.S.C. § 1396a[a][25]). Accordingly, participating providers are required to determine whether health care expenses can be submitted in the first instance to Medicare or some other payor before submission to Medicaid (*see* 18 N.Y.C.R.R. § 540.6[e][1], [2], [6]). This assessment is particularly critical for persons who are dually eligible for health services under both Medicare and Medicaid.

At the time of Medicaid claim submission, the State does not know what efforts were taken by providers to secure payment from other sources, including Medicare. Medicaid claims are therefore subject to post-payment review through the Medicaid Maximization program (MedMax). New York has contracted with a private entity—the Center for Medicare Advocacy (CMA)—to perform MedMax claim eligibility review. CMA is charged with evaluating whether health care claims that were paid by Medicaid should have been submitted for reimbursement to Medicare or another payor. If CMA identifies improperly disbursed payments, it assists DOH in recovering the funds previously paid to providers.

During the time frame relevant to this appeal (October 1993 to September 1998), VNS billed Medicaid for approximately $1.7 billion in health care services. After conducting the MedMax review and finding that certain recipients were dually eligible, CMA concluded that $38.2 million of those Medicaid payments should have qualified for reimbursement by Medicare or other third-party payors. Upon resubmission to Medicare, the

federal program paid about $28.4 million to VNS and, in turn, VNS refunded an almost identical amount to the State to satisfy the improper Medicaid charges. Medicare did not, however, accept the remaining approximately $10 million of VNS claims because too much time had elapsed from the date the health care services were rendered,[1] or due to errors by the provider. These so-called "provider liability" claims—those disputed Medicaid payments for which VNS was not able to receive compensation by Medicare or another payor—are the subject of this dispute.

DOH began to offset the outstanding $10 million in alleged improper Medicaid payments by withholding other Medicaid revenue due VNS. As a consequence, by December 2002, DOH had recouped over $2 million. VNS responded by initiating this CPLR article 78 proceeding challenging the State's withholding of Medicaid funds, asserting that it was not obligated to repay Medicaid unless it had actually received payment for the services provided from Medicare or some other source. VNS also contested DOH's recoupment procedures on the ground that no administrative hearing had been available for VNS to contest DOH's actions.

Supreme Court granted the provider's petition, concluding that VNS had a property interest in the Medicaid payments that was protected by due process and, as such, DOH was required to conduct a hearing before recovering Medicaid funds from VNS. The Appellate Division affirmed, similarly ruling that VNS was entitled to a hearing to determine if reasonable measures had been undertaken to assess whether the disputed claims were eligible for payment by Medicare or other third-party payors before submission to Medicaid. State recoupment efforts were stayed by the court because DOH had failed to comply with its own regulatory time frames for conducting hearings. The Appellate Division did, however, agree with DOH's contention that recoupment of provider liability claims was permissible in those instances where VNS failed to engage in reasonable efforts to ascertain whether services were Medicaid-eligible and to satisfy any conditions of approval by that program. Upon the Appellate Division's certification of a question to us,[2] we conclude that a hearing must be held on the issue of whether VNS took reasonable measures to ensure the proper designation and processing of claims.

DOH argues that notice and an opportunity to be heard need not be provided to VNS before recoupment efforts are undertaken because Medicaid payments to home health care providers are conditional pending post-payment MedMax review. But this contention is inconsistent with the regulatory scheme promulgated by DOH. Nothing in the relevant regulations indicates that payments to home health care providers are contingent on post-payment audits (*see* 18 N.Y.C.R.R. 505.23[e]; *see also* 18 N.Y.C.R.R. parts 517, 518 and 519). DOH's reliance on the regulatory provisions that govern payments to nursing homes is misplaced since those regulations specifically state that reimbursement rates are "provisional" until an "audit is performed and completed" (10 N.Y.C.R.R. 86-2.7; *see Matter of Cortland Nursing Home v Axelrod*, 66 N.Y.2d 169, 178–179 [1985]). A similar condition does not appear in the regulations pertaining to home health care providers (*see* 18 N.Y.C.R.R. 505.23[e]).

Instead, the regulations that cover home health care providers state that if DOH "determine[s] that any person has submitted or caused to be submitted claims for medical care, services or supplies for which payment should not have been made, it may require repayment of the amount determined to have been overpaid" (18 N.Y.C.R.R. 518.1[b]). "Overpayment" is defined as "any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake" (18 N.Y.C.R.R. 518.1[c]). "[W]hen a determination is made that an overpayment has been made, any person from whom recovery is sought is entitled to a notice of the overpayment and an opportunity to be heard" (18 N.Y.C.R.R. 518.5[a]) unless "the department or its fiscal agent adjusts or denies a claim prior to payment or withholds payment pursuant to a notice of withholding" (18 N.Y.C.R.R. 518.5[b]).

DOH contends that its "overpayment" definition is a term of art that it has interpreted to exclude provider liability claims and, consequently, VNS does not have a right to a hearing under 18 N.Y.C.R.R. 518.5(a). Although it is true that an agency's interpretation of its own regulation generally is entitled to deference, courts are not required to embrace a regulatory construction that conflicts with the plain meaning of the promulgated language (*see Matter of 427 W. 51st St. Owners Corp. v Division of Hous. & Community Renewal*, 3 N.Y.3d 337, 342 [2004]). The funds sought to be recovered by DOH fall within the broad definition of "overpayments" in 18 N.Y.C.R.R. 518.1(c) and, therefore, deference to DOH's interpretation is not warranted under the circumstances. As a result, VNS has the right to "notice of the overpayment and an opportunity to be heard" on the issue of overpayment recoupment (18 N.Y.C.R.R. 518.5[a]; *see* 18 N.Y.C.R.R. 519.4[a]).[3]

We next address whether DOH was properly ordered to cease recoupment pending the administrative hearing. VNS concedes that, as a general proposition, DOH is not required to conduct a hearing prior to seeking recoupment of Medicaid funds (*see Clove Lakes Nursing Home v Whalen*, 45 N.Y.2d 873, 875 [1978]).

Departmental regulations permit recoupment efforts to commence prior to a hearing (*see* 18 N.Y.C.R.R. 518.8). Significantly, the same regulation further provides that "if the department is unable to proceed within 90 days of receipt of [a] request [for a hearing], any recovery . . . will be stayed pending the commencement of the hearing" and "any delays . . . occasioned by or attributable to the department will forestall the commencement or continuation of recoupment" (18 N.Y.C.R.R. 518.8[b]). In light of DOH's failure to comply with the prescribed 90-day time frame, it was properly barred from continuing to withhold the Medicaid payments in this case pending an administrative hearing.

As the courts below also concluded, the purpose of the hearing will be to consider whether VNS should be relieved of its obligation to repay the contested Medicaid claims. A health care provider is not required to reimburse DOH for services that were paid by Medicaid if the provider "produce[s] acceptable documentation to the department that the provider reasonably attempted to ascertain and satisfy any condition of approval or other claiming requirements of liable third-party payors" (18 N.Y.C.R.R. 540.6[e][6]). Whether a provider satisfies this test requires examination of both the provider's initial assessment that a claim was not eligible for Medicare or other third-party reimbursement and its actions after being notified that a Medicaid-reimbursed claim should be resubmitted to a different payor. At the hearing, the burden will be on VNS to prove that it acted reasonably when it decided to submit the claims at issue to Medicaid rather than to Medicare or other payors and when it was subsequently notified by CMA that certain claims should be resubmitted for Medicare reimbursement eligibility. Recoupment by DOH is prohibited only with respect to claims for which VNS acted reasonably in both instances.

Finally, VNS asks us to decide whether federal law precludes DOH from seeking reimbursement for provider liability claims. VNS, however, did not cross-move to appeal and therefore may not obtain affirmative relief in this Court (*see 511 W. 232nd Owners Corp. v Jennifer Realty Co.*, 98 N.Y.2d 144, 151 n 3 [2002]). Accordingly, the order of the Appellate Division should be affirmed, with costs, and the certified question answered in the negative.

Order affirmed, with costs, and certified question answered in the negative. Opinion by Judge GRAFFEO. Chief Judge KAYE and Judges G.B. SMITH, CIPARICK, ROSENBLATT, READ and R.S. SMITH concur.

Endnotes

1. Medicare regulations deem a claim to be timely if it is submitted by the end of the calendar year that follows the fiscal year during which the health care service was provided (i.e., a service provided during fiscal year 2000-2001 had to be submitted by December 31, 2002) (*see* 42 C.F.R. 424.44 [a]).
2. The Appellate Division, Third Department, asked: "Did this Court err, as a matter of law, in affirming the judgment of Supreme Court, which partially granted petitioner's application, in a proceeding pursuant to CPLR article 78, to annul a determination of respondent Department of Health directing recoupment of Medicaid overpayments made to petitioner?"
3. It is unnecessary for us to address DOH's argument that due process is satisfied by the MedMax review procedure because a distinct administrative hearing is compelled by the cited regulations.

A Guide to New York State Laws Governing Public Health Emergency Preparedness and Response

Editor's Note: This Guide appears as Appendix 1-G to the Pandemic Influenza Plan issued by the NYS Department of Health in February 2006. The full report can be found at www.health.state.ny.us/diseases/communicable/influenza/pandemic/index.htm

This compilation of New York State statutory and regulatory authority is intended as a convenient resource for state and local health officials involved in planning for potential bioterrorism and other public health emergencies, including those arising from a radiological source.

I. Planning for a Public Health Emergency

A. Disaster Preparedness Public Policy Statement

Authority: Executive Law 20(1) states that it is the policy of the State that:

(a) local government and emergency service organizations continue their essential role as the first line of defense in times of disaster, and that the State provide appropriate supportive services to the extent necessary;

(b) local chief executives take an active and personal role in the development and implementation of disaster preparedness programs and be vested with authority and responsibility in order to assure the success of such programs;

(c) State and local natural disaster and emergency response functions be coordinated in order to bring the fullest protection and benefit to the people;

(d) State resources be organized and prepared for immediate effective response to disasters which are beyond the capability of local governments and emergency service organizations; and

(e) State and local plans, organizational arrangements, and response capability required to execute the provisions of Executive Law Article 2-B (Disaster Preparedness) shall at all times be the most effective that current circumstances and existing resources allow.

B. Disaster Preparedness Commission Plan

Authority: Executive Law 21 provides for the creation of a Disaster Preparedness Commission,which includes the commissioners of the following State agencies: Health, Transportation, Division of Criminal Justice Services, Education, Economic Development, Agriculture and Markets, Housing and Community Renewal, General Services, Labor, Environmental Conservation, Mental Health, State Energy Research and Development Authority, State Police, Insurance, Banking, and State. The Disaster Preparedness Commission also includes the State Fire Administrator, the chair of the Public Service Commission, the Adjutant General, the chairman of the State Thruway Authority, the chief professional officer of the State coordinating chapter of the American Red Cross and other members appointed by the Governor.

Among the Disaster Preparedness Commission's duties set forth at Executive Law 21(3)(c) is the duty to prepare State disaster preparedness plans.

C. Civil Defense Drills

Authority: Executive Law 29-b(1) provides that the Governor may, in his discretion, direct the State Civil Defense Commission to conduct a civil defense drill, under its direction, in which all or any of the civil defense forces of the State may be utilized to perform the duties assigned to them in a civil defense emergency, for the purpose of protecting and preserving human life in a disaster. In such event, civil defense forces in the State shall operate under the direction and command of the State Director of Civil Defense, who is, pursuant to Military Law 11, the Adjutant General.

Executive Law 29-b(2) and (3) respectively set forth provisions governing use of civil defense forces by the chief executives of counties and cities, including provisions relating to drills.

II. Reporting and Detection

The ability to detect and respond effectively to an unannounced act of bioterrorism may depend significantly upon timely and complete reporting of cases of communicable disease.

A. Primary Reporters of Cases of Communicable Disease and Other Indicators of Disease Outbreak

1. Local Health Officers Outside the City of New York

What is reported: All cases of such communicable diseases as may be required by State Department of Health (DOH).

Report made to: State DOH

Manner of reporting: Original reports or summary reports when authorized by State DOH.

When reported: Promptly

Authority: Public Health Law 2103 requires every local health officer to report promptly to the State DOH all cases of communicable diseases as may be required by State DOH. Public Health Law 2110 excepts the provisions of Public Health Law 2103 from applying to the City of New York. See instead New York City Health Code Article 11.

2. County Health Commissioners Outside the City of New York

What is reported: Original reports of communicable disease cases.

Report made to: State DOH.

Manner of reporting: Original reports or summary reports when authorized by State DOH.

When reported: Within 24 hours after receipt by county health commissioner.

Authority: Public Health Law 2104(1) requires the health officer of each city, village, town and consolidated health district included as part of any county or part-county health district, to transmit daily all original reports of communicable disease cases to the county health commissioner. Public Health Law 2104(2) requires the county health commissioner to transmit to State DOH the original reports of communicable disease cases within 24 hours after he or she receives them. Public Health Law 2110 excepts the provisions of Public Health Law 2104 from applying to the City of New York. See instead New York City Health Code Article 11.

3. Hospitals

What is reported: "Case," defined in 10 N.Y.C.R.R. 2.2(b) as a person diagnosed to have a particular disease or condition; "outbreak," defined in 10 N.Y.C.R.R. 2.2(c) as an increased incidence of disease above its expected baseline level.

Report made to: State DOH and to the city, county or district health officer.

When reported: Not specified.

Manner of reporting: As specified by the Commissioner of Health (10 N.Y.C.R.R. 405.11(c).

Authority: Public Health Law 201(1)(c) authorizes DOH to supervise the reporting and control of disease. Public Health Law 2803(1)(a) grants the Commissioner of Health the power to inquire into the operation of hospitals. 10 N.Y.C.R.R. 405.11(c), which requires the hospital professional responsible for the hospital-wide infection control program to report to DOH any increased incidence of no socomial infections, must be read with the 10 N.Y.C.R.R. 2.2(a) definition, which states that, "for public health reporting purposes, hospital associated infections include outbreaks or increased incidence of disease due to microbiological agents or their toxic products." 10 N.Y.C.R.R. 2.1 specifies the infectious, contagious or communicable diseases which must be reported pursuant to various provisions contained within 10 N.Y.C.R.R. Part 2 (Communicable Diseases), which was promulgated pursuant to Public Health Law 225. No socomial infections are reportable by hospitals pursuant to 10 N.Y.C.R.R. 405.11(c).

4. Physicians Outside the City of New York

What is reported: The full name, age and address of every person with a suspected or confirmed case of a communicable disease or any outbreak of communicable disease, together with the name of the disease, and any additional information requested by the health officer in the course of a communicable disease investigation.

Report made to: City, county or district health officer within whose jurisdiction the patient is.

When reported: Immediately or within 24 hours from the time the case is first seen by the physician.

Manner of reporting: Telephone, facsimile and other electronic transmission if indicated, and also in writing unless the State Health Commissioner approves waiver of written notice.

Authority: Public Health Law 2101 requires that every physician shall immediately give notice of every case of communicable disease required by State DOH to be reported to it, to the health officer of the local health district where such disease occurs. Existing regulations promulgated pursuant to Public Health Law 225, and set forth at 10 N.Y.C.R.R. 2.10, require every physician to report to the city, county, or district health officer, within whose jurisdiction the patient is, specified information concerning every person with a suspected or confirmed case of a communicable disease or any outbreak of communicable disease, within 24 hours from the time the case is first seen by the physician. Reports shall be made by telephone, facsimile or other electronic transmission if indicated, and shall also be made in writing, except that the written notice may be omitted with the approval of the State Commissioner of Health. Although direct reporting to State DOH is not currently required, when a communicable disease is reported to a city, county or district health officer, a copy is retained in that office, and another copy of the report must be reported to State DOH, pursuant to 10 N.Y.C.R.R. 2.1(b).

5. Physicians Within the City of New York

Authority: Public Health Law 2110 excepts the City of New York from, among other requirements, the provisions of Public Health Law 2101 described in paragraph 4 above. See instead New York City Health Code Article 11.

6. Nursing Homes, Diagnostic and Treatment Centers, Other Public Health Law Article 28 Facilities

What is reported: Cases of communicable diseases as defined in 10 N.Y.C.R.R. 2.2(b).

Report made to: State DOH and to the city, county or district health officer in whose jurisdiction the institution is located.

When reported: Not specified.

Manner of reporting: Not specified.

Authority: 10 N.Y.C.R.R. 2.10(a) provides that when a case of communicable disease occurs in a facility licensed under Article 28 of the Public Health Law, the person in charge of the facility shall report the case to the State Department of Health and to the city, county or district health officer in whose jurisdiction the institution is located.

7. Clinical Laboratories

What is reported: Identity of person from whom specimen is taken, name of physician sending specimen, other facts pertinent to the examination. Tests performed and such other information as the Department of Health may require to carry out the provisions of Title V, Article 5 of the Public Health Law. Also, such information and data concerning the laboratory's technical operation as may be specified by the Department.

Report made to: Local health official and State DOH.

When reported: Immediately for communicable disease reporting.

Manner of reporting: In a form prescribed by the Department.

Authority: Public Health Law 2102(1) requires that when any laboratory examination discloses evidence of communicable disease, the results of such examination together with all required pertinent facts, shall be immediately reported by the person in charge of the laboratory or the person making such examination to the local or state health official to whom the attending physician is required to report such case. Public Health Law 576(2) authorizes the State DOH to require clinical laboratories and blood banks to submit, in a form prescribed by the Department, periodic reports of tests performed and such other information as the Department may require to carry out the provisions of Title V, Article 5. 10 N.Y.C.R.R. Part 58-1.11(a) states that when requested, a laboratory shall submit reports containing such information and data concerning its technical operation as may be specified by the Department.

8. State Institutions

What is reported: Cases of communicable diseases.

Report made to: State DOH and to city, county or district health officer.

When reported: Not specified.

Manner of reporting: Not specified.

Authority: Public Health Law 2105 requires the director or person in charge of each state institution to report immediately an outbreak of a communicable disease in such institution to the State Health Commissioner and as may otherwise be provided in the State Sanitary Code. 10 N.Y.C.R.R. 2.10(a) provides that when a case of communicable disease occurs in a State institution or a facility licensed under Article 28 of the Public Health Law, the person in charge of the institution or facility shall report the case to the State Department of Health and to the city, county or district health officer in whose jurisdiction such institution is located.

9. Public Health Nurses and All Other Persons When No Physician Is in Attendance

What is reported: The name and address of any individual affected with any disease presumably communicable.

Report made to: City, county or district health officer.

When reported: Immediately.

Manner of reporting: Not specified.

Authority: 10 N.Y.C.R.R. 2.12 provides that when no physician is in attendance, it shall be the duty of the head of a private household or the person in charge of any institution, school, boarding house, camp or vessel or any public health nurse or any other person having knowledge of an individual affected with any disease presumably communicable, to report immediately the name and address of such person to the city, county, or district health officer.

10. Coroners, Medical Examiners, Pathologists

What is reported: Case of any individual who at time of death was apparently affected with a communicable disease, based on examination of the corpse or from history of events leading to death.

Report made to: City, county or district health officer.

When reported: Within 24 hours of determination.

Manner of reporting: By telephone, facsimile transmission or other electronic communication if indicated, and also in writing, except that the written notice may be omitted with the approval of the State Health Commissioner.

Authority: 10 N.Y.C.R.R. 2.11 provides that if a pathologist, coroner, medical examiner, or other person determines from examination of a corpse or from history of the events leading to death that at the time of death this individual apparently was affected with a communicable disease, he/she shall report the case within 24 hours to the proper health authority according to the manner indicated in 10 N.Y.C.R.R. 2.10 as if the diagnosis had been established prior to death. Note that the State Department of Health is not a direct recipient of such information pursuant to 10 N.Y.C.R.R. 2.10 but is an indirect recipient pursuant to 10 N.Y.C.R.R. 2.1(b).

B. Regulation of Live Pathogenic Microorganisms or Viruses

Authority: This is an area regulated primarily by the Federal government. It is important because of the potential threat of diversion of dangerous pathogens for bioterrorism. In addition to the State law cited below, see also Title 42 Code of Federal Regulations Part 72, entitled Interstate Shipment of Etiologic Agents, promulgated pursuant to the Antiterrorism Act of 1996, Pub.L. No. 104-132 which, among other things, directed the Federal Centers for Disease Control and Prevention to establish a regulatory scheme to identify biological agents posing a threat to the public health and to regulate their transfer and use through Federal rule. See also the USA Patriot Act of 2001 (Pub. Law 107-56, section 817); 18 U.S.C. 175 and 175b. Public Health Law Article 32 (Live Pathogenic Microorganisms or Viruses) requires that no person other than a licensed practitioner of medicine, dentistry, or veterinary medicine or a person under their direct supervision shall possess or cultivate live pathogenic microorganisms or viruses other than vaccine virus, subject to certain exceptions. Public Health Law 3201(1), (2) requires that no person shall sell or convey any live pathogenic microorganisms or viruses other than vaccine virus to any other person without permission from the State Commissioner of Health, or the New York City Health Department if within that city. However, this requirement does not apply to diseased tissue, exudate, or other specimens which are sent by physicians, dentists or veterinarians to laboratories for examination as an aid to the diagnosis or control of disease.

III. State and Local Government Response Provisions

A. At Onset of Public Health Emergency

1. Actions of the Governor

a. Governor May Declare a Disaster Emergency

Authority: Executive Law 28(1), (3) provides that whenever the Governor, on his own initiative or pursuant to a request from one or more chief executives, finds that a disaster has occurred or may be imminent, for which local governments are unable to respond adequately, he shall declare a disaster emergency by executive order, which describes the disaster and affected area, and which remains in effect for a period not to exceed 6 months unless extended by executive order for additional limited periods.

Disaster is defined at Executive Law 20(2)(a) as the occurrence or imminent threat of widespread or severe damage, injury, or loss of life or property resulting from any natural or man-made causes, including, but not limited to, fire, flood, earthquake, hurricane, tornado, high water, landslide, mudslide, wind, storm, wave action, volcanic activity, epidemic, air contamination, blight, drought, infestation, explosion, radiological accident, water contamination, bridge failure or bridge collapse.

State disaster emergency is defined at Executive Law 20(2)(b) as a period beginning with a declaration by the Governor that a disaster exists and ending upon its termination.

b. Governor May Invoke the New York State Defense Emergency Act of 1951

Authority: The New York State Defense Emergency Act of 1951 (Chapter 784, Laws of 1951), could be invoked following an "attack," defined to include any case involving use of bacteriological or biological means, thereby empowering a State Defense Council, chaired by the Governor, to exercise a broad range of extraordinary powers. (See appendices which contain the complete statute).

2. Local Government Actions

a. Chief Executive of a County, City, Town or Village May Proclaim a Local State of Emergency

Authority: Executive Law 24(1) provides that specified chief executives (defined at Executive Law 20(2)(f)) may proclaim a local state of emergency within any part or all of the territorial limits of such local government under specified circumstances.

Local state of emergency may arise in the event of a disaster, rioting, catastrophe, or similar public emergency within the territorial limits of any county, city, town or village. See Executive Law 24(1).

B. During Public Health Emergency

1. Actions of the Governor

a. Governor May Temporarily Suspend State and Local Laws and Regulations Under Specified Conditions

Authority: Under Executive Law 29-a, the Governor may, by executive order and subject to the State and

Federal Constitutions and Federal statutes and regulations, and after seeking the advice of the Disaster Preparedness Commission, temporarily suspend specific provisions of any statute, local law, ordinance, or orders, rules or regulations, or parts thereof, of any agency during a state disaster emergency, if compliance with such provisions would prevent, hinder, or delay action necessary to cope with the disaster.

b. Governor Shall Take Specified Actions Following Declaration of Disaster Arising from Radiological Accident

Authority: Executive Law 28(2) requires that upon the Governor's declaration of a disaster arising from a radiological accident, the Governor or his designee, shall direct one or more chief executives and emergency services organizations to: (a) notify the public that an emergency exists; and (b) take appropriate protective actions pursuant to the radiological emergency preparedness plan approved pursuant to sections 22 and 23 of the Executive Law. The Governor or his designee shall also have the authority to direct that other actions be taken by such chief executives pursuant to their authority under Executive Law 24.

c. Governor May Request Federal Assistance

Authority: Executive Law 28(4) provides that whenever the Governor finds that a disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and the affected jurisdictions, he shall make an appropriate request for Federal assistance available under Federal law, and may make available out of any funds provided under the governmental emergency fund or such other funds as may be available, sufficient funds to provide the required State share of grants made under any Federal program for meeting disaster-related expenses.

d. Governor May Direct State Agencies to Provide Disaster Emergency Assistance

Authority: Executive Law 29 provides that upon the declaration of a state disaster emergency, the Governor may direct any and all agencies of the state government to provide assistance under the coordination of the Disaster Preparedness Commission. Such State assistance may include: (1) utilizing, lending, or giving to political subdivisions, with or without compensation, equipment, supplies, facilities, services or state personnel, and other resources, other than the extension of credit; (2) distributing medicine, medical supplies, food and other consumable supplies through any public or private agency authorized to distribute such items; (3) performing on public or private lands temporary emergency work essential for the protection of public health and safety, clearing debris and wreckage, making emergency repairs to and temporary replacements of public facilities of political subdivisions damaged or destroyed as a result of such disaster; and (4) making such other use of their facilities, equipment, supplies and personnel as may be necessary to assist in coping with the disaster or any resulting emergency.

e. Governor May Order the Organized Militia into Service of the State

Authority: Military Law 6(1) provides that the Governor shall have power, in case of disaster, to order the organized militia into the active service of the State for such period, to such extent, and in such manner as he may deem necessary. Pursuant to Military Law 9, whenever the organized militia is employed under Military Law 6, the Governor may by proclamation declare the county or city in which the troops are serving to be under martial rule, if in the Governor's judgment the maintenance of law and order will thereby be promoted. Martial rule is subject to the Federal and State Constitutions and is governed by the Code of Military Justice. See Military Law Article VII.

f. Governor May Issue Call to the State Police

Authority: Executive Law 223(1) sets forth the duties and powers of the Superintendent and members of the New York State Police. The State Police are subject to the call of the Governor and are empowered to cooperate with any other department of the State or with local authorities. Upon the direction of the Governor or upon the request of the mayor of a city with the approval of the Governor, the State Police may exercise their powers within the limits of any city to suppress rioting and disorder.

g. Governor May Require State Health Commissioner to Examine Nuisances and Order Their Abatement or Removal

Authority: Public Health Law 1301(1) provides that whenever required by the Governor, the State Commissioner of Health shall make an examination concerning nuisances or questions affecting the security of life and health in any locality, and shall report the results to the Governor within the time prescribed by him. The Governor may declare the matters public nuisances and may order them to be changed, abated or removed as he may direct, pursuant to Public Health Law 1301(2). Pursuant to Public Health Law 1301(3), the Governor may, by a precept under his hand and official seal, require the district attorney, sheriff and other officers of the county where such nuisance is maintained, to take all necessary measures to execute such order and cause it to be obeyed. Application of these provisions to a situation arising from bioterrorism would assume the resulting contamination of property which might be identified and termed a public *nuisance*.

2. State Agency Actions

a. State Health Commissioner and New York State Department of Health Continue to Exercise Powers and Duties Regarding Public Health Matters as Provided by Law

Authority: Public Health Law 200 provides for the existence of a Department of Health in State government, headed by a Commissioner of Health of the State of New York. Public Health Law 206(1)(a) states the duty of the Commissioner of Health to take cognizance of the interests of public health and exercise functions, powers and duties prescribed by law.

Supervision of local boards of health and health officers—Public Health Law 206(1)(b) states the duty of the Commissioner of Health to exercise general supervision over the work of all local boards of health and health officers, unless provided otherwise.

Promulgation of regulations by Public Health Council—Public Health Law 225(4) and 225(5)(a) provide that the Public Health Council, which exists within the Department of Health, shall have the power to establish, amend and repeal regulations known as the State Sanitary Code, which may deal with any matters affecting the security of life or health or the preservation and improvement of public health in the State of New York and with any matters as to which the jurisdiction is conferred upon the Public Health Council.

Supervision of reporting and control of disease—Public Health Law 206(1)(d) states the duty of the Commissioner to investigate the causes of disease, epidemics, the sources of mortality and the effect of various factors on public health. Public Health Law 201(1)(c) states that the Department of Health shall, as provided by law, supervise the reporting and control of disease.

Supervision of nuisance abatement—Public Health Law 201(1)(n) requires the Department to exercise control over and supervise the abatement of nuisances affecting or likely to affect public health. Public Health Law 1300 confers on the Commissioner of Health all necessary powers to make investigations and examinations into nuisances, or questions affecting the security of life and health in any locality. Pursuant to Public Health Law 1303(4) and 10 N.Y.C.R.R. 8.5, the Commissioner of Health may mandate that local boards of health outside of New York City convene and take directed action necessary for the public good, including the abatement of the spread of disease.

Deputization of local health officers—Pursuant to Public Health Law 206(9), the Commissioner of Health may deputize in writing any local health officer to do or perform in her place and stead those duties set forth at Public Health Law 206(1)(d) pertaining to the investigation of the causes of disease, epidemics, the sources of mortality, and the effect of localities, employments and other conditions, upon the public health.

Modification of local board of health orders—Pursuant to Public Health Law 206(4)(b), the Commissioner of Health may annul or modify an order, regulation, by-law or ordinance of a local board of health concerning a matter which in her judgment affects the public health beyond the territory over which such local board of health has jurisdiction.

Access to facilities and property—Pursuant to Public Health Law 206(2), the Commissioner of Health or designee may, without fee or hindrance, enter, examine and survey all grounds, erections, vehicles, structures, apartments, buildings and places.

Expenditure of funds—Public Health Law 201(1)(p) provides that the Department of Health shall receive and expend funds for public health purposes as provided by law.

Distribution of products—Public Health Law 201(1)(e) requires the Department of Health to produce, standardize and distribute diagnostic, prophylactic and therapeutic products as provided by law.

Regulation of public health aspects of radiation—Public Health Law 201(1)(r) requires the Department of Health to supervise and regulate the public health aspects of ionizing radiation and non-ionizing electromagnetic radiation.

Promotion of disease education—Public Health Law 201(1)(g) requires the Department of Health to promote education in the prevention and control of disease as provided by law.

b. State Health Commissioner May Take Summary Action to Protect Public Health

Authority: Public Health Law 16 provides that whenever the Commissioner, after investigation, is of the opinion that any person is causing, engaging in or maintaining a condition or activity which in her opinion constitutes danger to the health of the people, and that it therefore appears to be prejudicial to the interests of the people to delay action for 15 days until an opportunity for a hearing can be provided in accordance with the provisions of Public Health Law section 12-a, the Commissioner shall order the person, including any State agency or political subdivision having jurisdiction, by written notice to discontinue such dangerous condition or activity or take certain action immediately or within a specified period of less than 15 days. As promptly as possible thereafter, within not to exceed 15 days, the Commissioner shall provide the person an opportunity to be heard and to present any proof that

such condition or activity does not constitute a danger to the health of the people.

c. Commissioner of General Services May Authorize State Agency Emergency Procurements

Authority: State Finance Law 163(10)(b) provides that procurements made to meet emergencies arising from unforeseen causes may be made without a formal competitive process and shall only be made under unusual circumstances and shall include a determination by the Commissioner of General Services or the State agency that the specifications or requirements for the purchase have been designed in a fair and equitable manner. The purchasing agency is required to document in the procurement record the nature of the emergency giving rise to the procurement.

Emergency is defined at State Finance Law 163(1)(b) as an urgent and unexpected requirement where health and public safety or the conservation of public resources is at risk.

3. Local Government Actions

a. Local Boards of Health and Health Officers Have the Duty and Authority to Control Infectious Diseases by Means that Include Isolation and Quarantine

Authority: Public Health Law 2100(1) requires every local board of health and every health officer to guard against the introduction of such communicable diseases as are designated in the State Sanitary Code, by the proper and vigilant medical inspection and control of all persons and things infected with or exposed to such diseases. Public Health Law 2100(2) places a legal duty upon local boards of health and health officers to: (a) provide for care and isolation of cases of communicable disease in a hospital or elsewhere when necessary for protection of the public health; and (b) subject to the provisions of the State Sanitary Code, prohibit and prevent all intercourse and communication with or use of infected premises, places, and things, and require, if necessary to provide the means for their thorough purification and cleansing before resumption of their use. Pursuant to Public Health Law 2110, New York City is exempt from the requirements contained in Public Health Law 2100. See New York City Health Code Article 11.

Isolation is defined at 10 N.Y.C.R.R. 2.25(d) as consisting of the separation from other persons, in such places, under such conditions, and for such time, as will prevent transmission of the infectious agent, of persons known to be ill or suspected of being infected.

Quarantine of premises is defined at 10 N.Y.C.R.R. 2.25(e) to consist of (1) prohibition of entrance into or exit from the premises, as designated by the health officer, where a case of communicable disease exists of any person other than medical attendants and such others as may be authorized by the health officer; (2) prohibition, without permission and instruction from the health officer, of the removal from such premises of any article liable to contamination with infective material through contact with the patient or with his secretions or excretions, unless such article has been disinfected. Pursuant to 10 N.Y.C.R.R. 2.29, whenever a case of a highly communicable disease (as defined in 10 N.Y.C.R.R. 2.1) comes to the attention of the city, county or district health officer, he or she shall isolate such patients as in his or her judgment are deemed necessary. Pending official action by the health officer, it is the legal duty of every attending physician, upon discovering a case of a highly communicable disease (as defined in 10 N.Y.C.R.R. 2.1) to immediately isolate the patient. 10 N.Y.C.R.R. 2.33 restricts the removal of persons affected with any highly communicable disease (as defined in 10 N.Y.C.R.R. 2.1) from one health district into another.

Under case law, including *Crayton v. Larabee* (1917) 220 N.Y. 493, isolation and quarantine must not be arbitrary, unreasonable or oppressive, and due process protections must be afforded to persons subject to isolation and quarantine orders of public health officers.

b. Local Boards of Health and Health Officers Have Duty to Investigate, Suppress and Remove Nuisances and Conditions Detrimental to Life and Health

Authority: Public Health Law 1303 provides that every local board of health and local health officer shall receive and examine all complaints concerning nuisances, or causes of danger or injury to life and health within the health district. Every local board of health shall order the suppression and removal of all such nuisances and conditions.

Application of this provision to a situation arising from bioterrorism would assume the resulting contamination of property which might be identified and termed a *nuisance*.

c. City Commissioner of Health (or Health Officer in Cities with Population of Less than 175,000) May Exercise Extraordinary Powers in Case of Great and Imminent Peril to the Public Health

Authority: Public Health Law 370(1) provides that in case of great and imminent peril to the public health of the city, it shall be the duty of the city health commissioner, or health officer in cities having a population of less than 175,000, with the approval and consent of the legislative authority if it is practicable to convene such authority for prompt action, or if not, when approved

by the board of estimate or similar authority, to take such measures and to do, order or cause to be done such acts and to make such extraordinary expenditures, in excess of the sum appropriated to the city department of health, as provided by law, for the preservation and protection of the public health of such city as he or she may deem necessary and proper.

d. Chief Executive of County, City, Town or Village May Promulgate Emergency Orders Following Proclamation of a Local State of Emergency

Authority: Executive Law 24(1) provides that following the proclamation of a local state of emergency and during its continuance, the chief executive may promulgate local emergency orders to protect life and property or to bring the emergency situation under control.

Control of roads and public areas—As illustration, such orders may, within any part or all or the territorial limits of such local government provide for: the establishment of a curfew and the prohibition and control of pedestrian and vehicular traffic, except essential emergency vehicles and personnel; the prohibition and control of the presence of persons on public streets and places.

Designation of emergency facilities—Such orders may also provide for the establishment or designation of emergency medical shelters.

e. Chief Executive of County, City, Town or Village May Suspend Local Law Under Specified Conditions

Authority: Pursuant to Executive Law 24(1)(g), a local emergency order may provide for the suspension within any part or all of its territorial limits of any of its local laws, ordinances or regulations, or parts thereof, subject to Federal and State constitutional, statutory and regulatory limitations, which may prevent, hinder, or delay necessary action in coping with a disaster or recovery from a disaster. This extraordinary power is first subject to two conditions: (1) a request has been made by the appropriate chief executive of the county or city to the Governor in accordance with Executive Law 24(7); or (2) the Governor has declared a state of disaster emergency pursuant to Executive Law 28. Also, such suspension of any local law, ordinance or regulation is subject to specified standards and limits:

(i) no suspension shall be made for a period in excess of 5 days, provided, however, that upon reconsideration of all the relevant facts and circumstances, a suspension may be extended for additional periods not to exceed 5 days each during the pendency of the state of emergency;

(ii) no suspension shall be made which does not safeguard the health and welfare of the public and which is not reasonably necessary to the disaster effort;

(iii) any such suspension order shall specify the local law, ordinance or regulation, or part thereof, suspended and the terms and conditions of the suspension;

(iv) the order may provide for such suspension only under particular circumstances, and may provide for the alteration or modification of the requirements of such local law, ordinance or regulation suspended, and may include other terms and conditions;

(v) any such suspension order shall provide for the minimum deviation from the requirements of the local law, ordinance or regulation suspended consistent with the disaster action deemed necessary; and

(vi) when practicable, specialists shall be assigned to assist with the related emergency actions to avoid adverse effects resulting from the suspension.

f. Chief Executive of County and Certain Chief Executives of Cities May Request Governor to Provide Assistance Following Declaration of Local State of Emergency Involving Disaster Beyond Capability of Local Government to Meet

Authority: Executive Law 24(7) provides that whenever a local state of emergency has been declared pursuant to this section, the chief executive of the county in which the local state of emergency has been declared, or where a county is wholly contained within a city, the chief executive of the city, may request the Governor to provide assistance under the Executive Law, provided that such chief executive determines that the disaster is beyond the capacity of local government to meet adequately and State assistance is necessary to supplement local efforts to save lives and to protect property, public health and safety, or to avert or lessen the threat of a disaster.

IV. Provisions Governing Critical Areas

A. Safe Disposal of Infectious Waste

Authority: See Public Health Law Article 13, Title XIII, entitled Storage, Treatment, and Disposal of Regulated Medical Waste. Included are the following definitions:

Regulated medical waste—1389-aa(1)

Infectious agents—1389-aa(5)

Cultures and stocks—1389-aa(1)(a)

Human pathological waste—1389-aa(1)(b)

Sharps—1389-aa(1)(d)

In addition, see 6 N.Y.C.R.R. 364.9, which establishes a program for tracking and managing medical waste shipments pursuant to the Environmental Conservation Law.

B. Safe Disposal of Human Remains

Authority: See generally Public Health Law Article 41, Title IV (Registration of Deaths: Burial Permits); and Public Health Law Article 42 (Cadavers). Public Health Law 4140 requires that in the case of a death occurring from a disease which is designated in the State Sanitary Code as a communicable disease, no permit for the removal or other disposition of the body shall be issued by the registrar, except to a funeral director or undertaker licensed in accordance with Public Health Law Article 34 (Funeral Directing), under such conditions as may be prescribed in the State Sanitary Code.

C. Destruction of Property

Authority: Public Health Law 2100(2)(b) provides that every local board of health and every health officer may, subject to the provisions of the State Sanitary Code, prohibit and prevent all contact with or use of infected premises, places and things, and require, and if necessary, provide the means for their thorough purification and cleansing before contact may be resumed. According to a 1894 Opinion of the Attorney General, it was within the power of a local board of health to destroy clothing which had become infected with infectious or contagious disease germs.

D. Licensing and Appointment of Health Personnel

1. Coroner, Coroner's Physician and Medical Examiner

Authority: Outside of New York City, County Law Article 17-A applies and describes their duties and manner of investigating deaths within their jurisdiction.

2. Physicians

Authority: Education Law Article 131 (Medicine); Education Law Article 131-A (definitions of professional misconduct applicable to physicians); Public Health Law 230 et seq. (Professional Medical Conduct); Public Health Law Article 33 (Controlled Substances)

3. Physician's Assistants

Authority: Education Law Article 131-B (Physician Assistants and Special Assistants); Education Law Article 131-A (definitions of professional misconduct applicable to physician's assistants and special assistants); Public Health Law Article 33 (Controlled Substances)

4. Nurses

Authority: Education Law Article 139 (Nursing); Public Health Law Article 33 (Controlled Substances)

5. Pharmacists

Authority: Education Law Article 137 (Pharmacy); Public Health Law Article 33 (Controlled Substances)

6. Veterinarians

Authority: Education Law Article 135 (veterinary medicine)

7. Emergency Medical Technicians

Authority: Public Health Law Article 30 (Emergency Medical Services); 10 N.Y.C.R.R. Part 800 (State Emergency Medical Services Code)

8. Funeral Directors

Authority: Public Health Law Article 34 (Funeral Directing)

E. Collection of Laboratory Specimens: Chain of Custody

Physical evidence of an act of bioterrorism may take the form of a biohazard specimen. Whenever such a specimen is to be appropriately collected by members of the health service system or law enforcement agencies and transported to an appropriate laboratory for testing (e.g., Wadsworth Center for Laboratories and Research), material submitted as physical evidence must comply with policies that ensure its integrity and safe handling.

Authority: Executive Law 995-b(1) requires the Commission on Forensic Science to develop minimum standards for all forensic laboratories in New York State. See also 9 N.Y.C.R.R. Part 6190 (New York State Accreditation Program for Forensic Laboratories).

F. Access to and Disclosure of Protected Health Information

Authority: In addition to State law cited below, recently enacted Federal law must also be considered. See especially the Federal Health Insurance Portability and Accountability Act (HIPAA). Accompanying regulations are not yet effective. However, the relevant privacy regulations implementing HIPAA are scheduled to take effect and require compliance on April 14, 2003.

Hospitals licensed under Public Health Law Article 28 are required to ensure the confidentiality of patient records. Original medical records, information from or copies of records shall be released only to hospital staff involved in treating the patient and individuals as permitted by Federal and State laws (10 N.Y.C.R.R. 405.10 (a)(5)).

Nursing homes must keep confidential all information contained in the residents' records except when release is required by the resident or by law (10 N.Y.C.R.R. 415.22 (d)).

Confidential HIV-related information is defined at Public Health Law 2780(7). No person who obtains such information in the course of providing any health or social services pursuant to a release of confidential HIV-related information may disclose or be compelled to disclose such information except as provided in Public Health Law 2782 and Article 27-F.

Release of patient medical records procedures are provided for in Public Health Law 17 upon the written request of the patient to an examining, consulting or treating physician or hospital.

Access to patient information is governed generally by Public Health Law 18.

V. Enforcement

Authority:

A. Criminal penalties—Public Health Law 12-b(2) provides that a person who wilfully violates any provision of the Public Health Law or any regulation lawfully made or established by any public officer or board under authority of the Public Health Law, the punishment for violating which is not otherwise prescribed by the Public Health Law or any other law, is punishable by imprisonment not exceeding one year, or by a fine not exceeding $2,000 or by both.

B. Physician discipline—A physician may be charged via the disciplinary processes of Public Health Law 230 with professional misconduct pursuant to Education Law 6530(16) for a willful or grossly negligent failure to make a communicable disease report required under 10 N.Y.C.R.R. 2.10.

C. Civil penalties—Pursuant to Public Health Law 12 and 206, any person, including health facilities licensed under Public Health Law Article 28, who violates any provision of the Public Health Law or regulations made pursuant to it shall be liable for a civil penalty not to exceed $2,000 for every such violation. A health facility licensed under Public Health Law Article 28 may subject its operating certificate to revocation, pursuant to Public Health Law 2806(1) for violation of the Public Health Law or applicable regulations, including communicable disease reporting requirements.

D. Obstruction or interference with State health inspector—No person shall interfere with or obstruct the inspection or examination of any occupant of any house, building, vessel or other premises by the State Commissioner of Health in discharge of her official duties (10 N.Y.C.R.R. 1.11).

NEWS flash

What's Happening in the Section

Recent Section Programs

- **2006 Section Annual Meeting.** At the Health Law Section's Annual Meeting, the program was on the timely and important topic of disaster preparedness. "Building Bridges Before and After the Flood: New York Healthcare Providers and Disaster Planning Response," was organized by the Public Health Committee of the Section and chaired by Margie Davino. It offered a formidable array of local and national experts on the topic, included several speakers with personal experience handling issues arising during and from the Katrina disaster, and from the World Trade Center attack.

(l to r) John Mattesino, President and CEO, Louisiana Hospital Assn; Margie Davino, Conference Chair

- **Annual Meeting Luncheon.** Continuing a long-standing tradition, the luncheon address was given by the General Counsel to the NYS Department of Health. This year, DOH General Counsel Donald Berens, Jr. offered an historical overview of public health crises, including the Great Influenza Epidemic of 1917-18. The other luncheon speaker was Joshua Lipsman, who received the Barry Gold Memorial Health Law Student Writing Competition for his article, *Public Health Emergencies in New York: Are We Legally Ready*, 10 NYS Health L.J. 87 (Summer/Fall 2005). Mr. Lipsman, who is the Westchester County Commissioner of Health as well as a Pace law student, emphasized the need to reform New York's antiquated laws relating to public health emergencies.

(l to r) Phil Rosenberg, Lynn Stansel, Donald Berens, Jr., Joshua Lipsman

Upcoming Programs

- **Representing Physicians and Dentists in the Disciplinary Process** (April 7 in Long Island; April 28 in NYC; May 5 in Albany; May 19 in Rochester). This program is being organized by Professional Disciplinary Committee Co-Chairs Ken Larywon of Martin, Clearwater & Bell, LLP, NYC, and Carolyn Shearer of Bond, Schoeneck & King, PLLC, Albany.

- **Long–Term Care and the Law: Issues and Skills** (May 12 in Rochester; May 12 in NYC; and May 19 in Albany). Ari Markenson of Epstein, Becker & Green, P.C. is organizing this program. It will include panels with key policymakers and officials from leading long–term care organizations.

- **Fall Program / Retreat will anticipate "Rightsizing."** In light of the success of last Fall's Program and Retreat, the Executive Committee decided to organize another Fall Program and Retreat for 2006. This one will be held Nov. 3-4 at the renowned Equinox Resort and Spa in Manchester Village, Vermont.

  The Program is expected to focus on legal issues relating to "rightsizing" hospitals and nursing homes, i.e., the closures, mergers, and other measures facilities will take, voluntarily or involuntarily, as a result of the impending report of the Commission on Health Care Facilities for the 21st Century. By statute, that report will be issued to the Governor on December 1, 2006, who then has until December

6, 2006, to present it to the Legislature. If he does so, it will become effective on December 31, 2006, unless the Legislature, before that date, acts to disapprove it.

The Equinox Resort and Spa is situated on 2,300 acres between the Green and Taconic Mountains. It offers spectacular views, a world-class spa, many amenities and activities, and proximity to the lovely New England town of Manchester. Members should consider bringing their family and staying the weekend.

Upcoming *Journal* Editions

- **Summer/Fall '06 Edition.** This edition of the *Journal* will carry articles on a variety of topics. Those who wish to submit an article should contact the *Health Law Journal* Editor, Robert N. Swidler, at 518-271-5027 or swidlerr@nehealth.com.
- **Winter '07 Edition.** This Special Edition will examine "Legal Issues in Managed Care in NY" and will include articles from authors who represent payors, providers and patients. The Special Edition Editor is Harold Iselin, a partner in Greenberg Traurig and counsel to the NYS HMO Conference. Any person who wishes to submit an article for this edition should contact one of the Special Edition Editors.

New Section Officers

The following new Section officers were elected at the 2006 Annual Meeting or, in the case of the Chair, at the 2005 Annual Meeting:

- **Chair—Mark Barnes.** Mark Barnes, the Section's current Chair-Elect, will become Chair of the Health Law Section on June 1, 2006. Mark, a partner in Ropes & Gray, has practiced and taught law and has administered government programs in the health care field for the past 20 years. Mark is recognized as one of the leading attorneys in the fields of research compliance, the practice and ethics of clinical trials, and medical privacy.

Mark Barnes

Mark represents medical schools, hospitals, and major pharmaceutical companies in matters related to scientific research, stem cell and genetic research, research grants, clinical trials, Medicare reimbursement, and medical privacy.

Educated at Yale Law School and Columbia University School of Law, Mark taught full time at Columbia for four years in the late 1980s, where he co-founded a clinical and academic program devoted to antidiscrimination and public health law. He served as the Director of Policy for the New York State Department of Health AIDS Institute in the early 1990s. In 1993, he was a consultant and a member of the legal review committee of the Clinton White House National Health Care Reform Task Force.

While serving from 1992 to 1994 as Associate Commissioner for Medical and Legal Policy for the New York City Department of Health, Mark wrote and politically managed New York City's adoption and enforcement of new regulations compelling treatment compliance among tuberculosis patients, in order to control the burgeoning tuberculosis epidemic. Also during that time, he was given charge of New York City Department of Health's AIDS care programs, which he reorganized and for which he secured $60 million in additional annual federal funding for these City programs. In the mid 1990s, Mark was the Executive Director of the AIDS Action Council, where he lobbied and advocated on AIDS funding and policy before Congress, federal agencies, and the Office of the President

- **Chair-Elect—Peter Millock.** Peter Millock is one of the founding members of the Health Law Section and a long-standing member of its Executive Committee. Peter is a partner in Nixon Peabody, LLP, and practices health law in its Albany office.

Peter Millock

Between 1980 and 1995, Peter served as general counsel to the New York State Department of Health. He was the chief legal advisor to the Commissioner of Health, managed the department's litigation and administrative enforcement actions involving nursing homes and hospitals, led the development of the state's policies on medical malpractice reform, and conducted investigations of ethics violations, health fraud, and public health threats.

Peter is a frequent speaker on health care issues, and is an associate professor at the State University of New York at Albany, School of Public Health. In 1993, he served on the President's Task Force on Health Care Reform as a member of the Legal Audit Team. Peter graduated from Harvard College and Harvard Law School.

As a result of the election at the Annual Meeting, Peter will be come Chair of the Section in June 2007.

- **Vice-Chair—Ross Lanzafame.** Ross Lanzafame is a partner in Harter Secrest & Emery in Rochester. Ross counsels long-term care and acute health care providers, particularly on reimbursement issues and regulatory compliance.
- **Secretary—Ed Kornreich.** Ed Kornreich is Co-Chair of the Health Law Department at Proskauer Rose, LLP, and works in its NYC office. Ed's practice is focused primarily on health care transactions, regulatory compliance and health care payment issues for varied providers.
- **Treasurer—Ari Markenson.** Ari Markenson is Associate General Counsel for Cypress Health Care Management, which manages nursing homes and other long-term care facilities.

Other Section and Committee Activities

- **Family Health Care Decisions Act Now a Top Priority for NYSBA.** On January 26, the NYSBA Executive Committee voted to make the Family Health Care Decisions Act one of its top legislative priorities for 2006. As a result, NYSBA will devote significant effort, and allocate significant resources, in support of the FHCDA. The Executive Committee considered taking this action at the request of the Health Law Section, as well as based on the recommendation of the NYSBA Legislative Committee.

  The other top priorities for the NYSBA relate to no fault divorce, access to the civil justice system for low and middle income New Yorkers, videotaping custodial interrogations in criminal cases, equal justice for same-sex couples, and increasing compensation for NYS judges.

Section Committees and Chairs

The Health Law Section encourages members to participate in its programs and to volunteer to serve on the Committees listed below. Please contact the Section Officers (listed on the back page) or Committee Chairs for further information about these Committees.

Biotechnology and the Law

Erik D. Ramanathan
Imclone Systems Incorporated
180 Varick Street, 6th Floor
New York, NY 10014
(212) 645-1405
Fax: (212) 645-2770
e-mail: erik.ramanathan@imclone.com

Consumer/Patient Rights

Randye S. Retkin
NY Legal Assistance Group
450 West 33rd Street, 11th Floor
New York, NY 10001
(212) 613-5080
Fax: (212) 750-0820
e-mail: rretkin@nylag.org

Mark Scherzer, Esq.
Law Offices of Mark Scherzer
7 Dey Street, Suite 600
New York, NY 10007
(212) 406-9606
Fax: (212) 964-6903
e-mail: mark.scherzer@verizon.net

Ethical Issues in the Provision of Health Care

Kathleen M. Burke
New York Presbyterian Hospital
525 East 68th Street, Room W-109
New York, NY 10021
(212) 746-4075
Fax: (212) 746-8994
e-mail: kburke@nyp.org

Fraud, Abuse and Compliance

Steven Chananie
Garfunkel, Wild & Travis
111 Great Neck Road
Great Neck, NY 11021
(516) 393-2224
Fax: (516) 466-5964
e-mail: schananie@gwtlaw.com

Marcia B. Smith
Iseman Cunningham Riester & Hyde, LLP
9 Thurlow Terrace
Albany, NY 12203
(518) 462-3000
Fax: (518) 462-4199
e-mail: msmith@icrh.com

Health Care Providers

Francis J. Serbaroli
Cadwalader Wickersham & Taft LLP
1 World Financial Center, 31-138
New York, NY 10281
(212) 504-6001
Fax: (212) 504-6666
e-mail: francis.serbaroli@cwt.com

In-house Counsel

Edward G. Case
University of Rochester
601 Elmwood Avenue, Suite 308
Rochester, NY 14642
(585) 275-5831
Fax: (585) 273-1024
e-mail: edward_case@urmc.rochester.edu

Long-Term Care

Ari J. Markenson
Cypress Health Care Management
44 South Broadway, Suite 614
White Plains, NY 10601
(914) 390-4300
Fax: (866) 280-2653
e-mail: amarkenson@cypresshealthcare.net

Managed Care

Robert P. Borsody
Phillips Nizer LLP
666 Fifth Avenue, 29th Floor
New York, NY 10103
(212) 977-9700
Fax: (212) 262-5152
e-mail: rborsody@phillipsnizer.com

Harold N. Iselin
Greenberg Traurig, LLP
54 State Street
Albany, NY 12207
(518) 689-1400
Fax: (518) 689-3499
e-mail: iselinh@gtlaw.com

Membership

Hon. James F. Horan
NYS Health Department
433 River Street
5th Floor, Suite 330
Troy, NY 12180
(518) 402-0748
Fax: (518) 402-0751
e-mail: jfh01@health.state.ny.us

Mental Health Issues

Henry A. Dlugacz
488 Madison Avenue, 19th Floor
New York, NY 10022
(212) 254-6470
Fax: (212) 813-9600
e-mail: hd@dlugacz.com

J. David Seay
National Alliance for the Mentally Ill
260 Washington Avenue
Albany, NY 12210
(518) 462-2000, x207
Fax: (518) 462-3811
e-mail: dseay@naminys.org

Mental Retardation/ Developmental Disabilities Providers

Hermes Fernandez
Bond Schoeneck & King, PLLC
111 Washington Avenue
Albany, NY 12210
(518) 533-3000
Fax: (518) 462-7441
e-mail: hfernandez@bsk.com

Nominating

James D. Horwitz
Glens Falls Hospital
100 Park Street
Glens Falls, NY 12801
(518) 926-1981
Fax: (518) 926-1988
e-mail: jhorwitz@glensfallshosp.org

Professional Discipline

Kenneth R. Larywon
Martin Clearwater & Bell, LLP
220 East 42nd Street
New York, NY 10017
(212) 916-0918
Fax: (212) 949-7054
e-mail: larywk@mcblaw.com

Carolyn Shearer
Bond, Schoeneck & King, PLLC
111 Washington Avenue
Albany, NY 12210
(518) 533-3000
Fax: (518) 533-3299
e-mail: cshearer@bsk.com

Public Health

Margaret J. Davino
Kaufman Borgeest & Ryan
99 Park Avenue, 19th Floor
New York, NY 10016
(212) 980-9600
Fax: (212) 980-9291
e-mail: mdavino@kbrlaw.com

Special Committee on Bylaws

Patrick Formato
Abrams Fensterman et al.
1111 Marcus Avenue, Suite 107
Lake Success, NY 11042
(516) 328-2300
Fax: (516) 328-6638
e-mail: pformato@abramslaw.com

Special Committee on Legislative Issues

James W. Lytle
Manatt, Phelps & Phillips LLP
30 S. Pearl Street, 12th Floor
Albany, NY 12207
(518) 431-6700
Fax: (518) 431-6767
e-mail: jlytle@manatt.com

Website Coordinator

Ross P. Lanzafame
Harter Secrest & Emery LLP
1600 Bausch and Lomb Pl.
Rochester, NY 14604
(585) 231-1203
Fax: (585) 232-2152
e-mail: rlanzafame@hselaw.com

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Persons interested in writing for this *Journal* are welcomed and encouraged to submit their articles for consideration. Your ideas and comments about the *Journal* are appreciated as are letters to the editors.

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Robert N. Swidler
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
(518) 271-5027
e-mail: swidlerr@nehealth.com

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Health Law Section
New York State Bar Association
One Elk Street
Albany, NY 12207-1002

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