Assisting Individuals in Need of Mental Health Services Through a Guardianship Lens

By Sara Chussler and Carolyn Reinach Wolf

According to the New York State Department of Health, one in ten New Yorkers experience mental health challenges that impact their ability to function.[1] In certain situations, the appointment of a Mental Hygiene Law (MHL) Article 81 guardian may be appropriate. An individual's functional limitations may be primarily caused by a mental illness, or their mental illness may be a contributing factor. In either scenario, prior to seeking the appointment of a MHL Article 81 guardian, an assessment of mental health services available, which may constitute a less restrictive alternative to a guardianship appointment, is warranted.[2] This assessment should review services already in place, additional services for which an individual in need is eligible, and a consideration of each service's purpose and limitations for the individual on a case-by-case basis.

Examples of mental health services available in the community include therapists, counselors, psychiatrists, Assisted Outpatient Treatment, Assertive Community Treatment (ACT), Forensic Assertive Community Treatment, Intensive Case Management, Partial Hospitalization Programs, residential treatment, and case management. These services may provide a comprehensive level of care to assist an individual who is challenged by a mental health issue and allow them to live safely in the community. Even with mental health services in place, there are occasions where a MHL Article 81 guardian may become necessary. In those instances, a guardian can coordinate with the mental health clinical providers to obtain and maintain the best possible outcome for the individual in need.

Assisted Outpatient Treatment or AOT

Assisted Outpatient Treatment (AOT), also known as Kendra's Law, is a court-mandated mental health treatment program codified by MHL § 9.60. Each county outside of New York City is responsible for maintaining an AOT program and jurisdiction is determined by the individual's place or residence. The New York City AOT is operated by the city Department of Health and Mental Hygiene.[3] A petition for AOT under the statute may be initiated by a number of individuals or entities including hospitals, parents, siblings, adult children, roommates, or the director of community services or his or her designee.[4] Statistically, in most circumstances, hospitals who provide acute inpatient psychiatric will serve as the petitioner.

When an individual who is subject to an AOT order is non-compliant with treatment and suffers a psychiatric decompensation, they may be brought to a hospital for a clinical evaluation and possible involuntary admission. This is commonly referred to as "an AOT removal."[5] The components of an AOT plan often include court-mandated psychiatric medications, follow-up with a psychiatrist, and can include various categories of services such as group therapy, individual therapy, vocational training, housing assistance, and substance abuse counseling, as well as periodic alcohol and drug testing.[6] AOT treatment plans must include either Assertive Community Treatment (ACT) teams or case management services (ICM: Intensive Case Manager) for coordination of the recipient's mental health care services.[7] An active AOT order may be an available resource for an AIP to address some of their functional limitations, specifically those relating to mental health treatment, and may help to prevent further multiple inpatient psychiatric hospitalizations, referred to by some as a revolving door.

A court order for AOT is typically limited in duration and an initial AOT court order is usually only effective for either six months or one year. As such, the availability of AOT as a long-term resource for an AIP is arguable.[8] Furthermore, to qualify for AOT, several statutory criteria must be met – a mental health diagnosis, standing alone, will not qualify an individual for AOT. Most significantly, the petitioner must prove that an individual's non-compliance with mental health treatment has resulted in two hospitalizations in the preceding 36 months, or resulted in an act of serious violence or threats or attempts at serious physical harm to themselves or others within the preceding 48 months of the application to the court.[9] The availability of AOT as an alternate resource to guardianship is thus further constrained by the statutory eligibility requirements and a high level of evidentiary proof. Moreover, "as the coercive force of the [AOT] order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives,"[10] AOT might be considered an insufficient resource for an individual who is unwilling to abide by the court's order.

Assertive Community Treatment

The New York State Office of Mental Health regulates the ACT program, which "offers treatment, rehabilitation, and support services, using a person-centered, recovery-based ap-

proach, to individuals that have been diagnosed with serious mental illness (SMI)."[11] For an individual in the community, an ACT team can provide a variety of hands-on services including at home visits, assistance with medication adherence, counseling and support services, vocational training, and other daily activity support such as assistance with grocery shopping or accompanying an individual to the pharmacy to assist with obtaining medications. If an individual assigned to an ACT team is admitted to a mental health facility, the ACT team will participate in discharge planning "to ensure an optimal transition" when the individual is discharged back home to the community.[12]

The process of being assigned to an ACT team begins with a referral or application to the Single Point of Access, known as (SPOA). SPOA processes referrals and matches an individual to an ACT team.[13] The referrals are typically made by hospitals, though family members and others in the community may apply. The assignment of an ACT team is based upon the individual's county of residence and enrollment availability. In practice, there can be a waiting period for the assignment of ACT services due to the high volume of individuals in need of these services. For example, according to data maintained by the Office of Mental Health, as of Sept. 11, 2024, there were 6,826 individuals enrolled across New York's 122 ACT teams.[14] Despite the addition of 14 new ACT teams since October of 2022, statewide there was an 86% enrollment capacity, and many programs are at or above maximum capacity.[15]

The limitations of ACT team availability and the enrollment criteria may limit the ACT team as an alternative resource to a MHL Article 81 guardianship. Another potential limitation to ACT services is that participation and cooperation by the subject individual is volitional and the individual has the right to refuse to engage with their ACT team. That being said, statistically individuals who receive ACT services over a three-year period generally experience increased medication adherence and decreased psychiatric hospitalizations, and experience increases in enrollment in educational courses and employment, and decreases in homelessness over the same period.[16]

Forensic Assertive Community Treatment

When an individual with a mental illness is involved with the criminal justice system, a Forensic Assertive Community Treatment (FACT) team can be assigned to provide similar services described above for ACT teams. The FACT team can work with an individual to prevent further criminal behavior, monitor the individual's risk for relapse, prevent further incarceration or hospitalization, and serve as diversion to jail or prison time.[17] To that end, the FACT team will develop a treatment plan for each individual served including annual screens for risks of violence and the completion of a violence risk assessment to address dynamic risk factors, defined as "characteristics of individuals and their environments that are related to the likelihood of recidivism after discharge."[18]

The FACT team should have a heightened level of understanding of the interplay between the criminal justice system and clinical needs of the individuals they serve. To strengthen these services, FACT team staffing must include a clinician, a criminal justice specialist, a criminal justice liaison, a housing specialist, and a peer specialist.[19]

Partial Hospitalization Program or PHP

Another form of a heightened level of mental health care in the community is a Partial Hospitalization Program (PHP). PHP is a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care. A PHP provides intensive day treatment where an individual receives individual and group therapy services for a set number of hours per day, multiple days a week, for a prolonged duration. Enrollment in a PHP can last for weeks or months. Through PHP an individual receives therapeutic services and skills training to transition back into or to remain safely the community, with the daily meetings there is oversight into their mental health treatment compliance and clinical presentation.

Residential Treatment and Mental Health Case Management

Where public services are either insufficient or not available, and the individual has means, residential treatment or private mental health case managers should be considered and may constitute an alternative available resource to the use of MHL Article 81 guardianship or may be an appropriate resource to augment the guardian's services.[20]

Residential treatment programs provide therapeutic programming across the country for voluntary placement. While a residential treatment program is a less restrictive setting than traditional inpatient psychiatric care, individuals enrolled are provided with clinical supervision, therapeutic services, medication management, and trained staffing available around-the-clock to assist their needs. Ideally, an individual who agrees to enroll and participate in a residential treatment program will learn and develop the skills necessary to sustain an independent living arrangement in the community once they have graduated from the program.

Private mental health case managers can assist an individual to remain safe at home in the community. Mental health case management services are provided by individuals trained and experienced in the mental health field. These case managers meet frequently with individuals to build relationships of trust, support, and understanding. Mental health case managers will explore benefits and programs available to an individual in need, and the mental health case manager will coordinate the delivery of services through state and local agencies or private organizations. This includes an assessment of the individual's current ability and needs, the appropriateness of the current housing and alternative housing options available, and services currently in place. Additionally, mental health case managers can advocate for services and provide hands on assistance to an individual by accompanying the individual to medical appointments to ensure attendance, assisting the individual with errands and grocery shopping to ensure their basic needs are met, and importantly, by monitoring the individual's overall well-being. In this latter regard, a mental health case manager provides an invaluable service by enabling a guardian or family to take immediate action to respond to an individual's mental health and functioning decline in the community.

Article 81 Guardianship in Conjunction With Mental Health Services

Where a guardianship is appropriate, a MHL Article 81 guardian for an individual suffering from a SMI should be aware of the foregoing services and consider establishing such services for the individual in need. If mental health support services are in place, the guardian should be in touch with the providers to coordinate services and assist the subject individual. This is particularly important as mental health treatment is a distinct area of health care where a MHL Article 81 guardian's powers are restricted. An Article 81 guardian has the authority to consent to routine and major medical treatment, but psychiatric treatment is excluded from these categories of healthcare treatment.[21] Particular attention should be paid to how and when an individual may be treated with psychotropic medications over their objection. The authority to involuntarily medicate an individual is governed by the decision of the Court of Appeals in *Rivers v. Katz*.[22]

In essence, a guardian may not consent to the administration of psychotropic medication to their ward. That is not to say that an Article 81 guardian is powerless to assist a mentally ill Incapacitated Person in obtaining much needed medications. A guardian could assist by scheduling doctor and therapy appointments, by ensuring services discussed herein are in place, coordinating those services, and by encouraging the individual to engage in treatment and to accept same. For example, to encourage acceptance of mental health treatment, a guardian of an individual whose symptoms result in overspending may step in to stop the financial bleeding and create a budget in connection with the individual's acceptance of mental health services. Likewise, where an individual is facing an eviction, the guardian can coordinate with the mental health community service team to secure appropriate housing.

The appointment of a guardian may only be needed for a limited duration to address a specific issue such as housing, finances, or medical care which other potentially available resources are unable to address, or depending on the severity and longevity of an individual's mental health symptoms, a guardianship with broader powers and for an indefinite duration may be warranted. In every instance, the goal of seeking guardianship for an individual with a mental illness should be to help return an individual to a stable and functional lifestyle.

Conclusion

When an individual in the community is in need of mental health services, the use of AOT, ACT, FACT, PHP, residential placement, or mental health case management, as appropriate, may be sufficient and may constitute a less restrictive alternative to guardianship. Where these services are either not available or are insufficient to meet an individual's needs, a MHL Article 81 guardian may be appropriate to work in conjunction with the clinical providers. By utilizing and coordinating the mental health services available with a track record of success, individuals with mental health diagnoses can be equipped with the services and support needed to live independently in the community.

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Endnotes

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