Office of Mental Health

Compliance With Jonathan's Law

Report 2018-S-22 | July 2019

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

Audit Highlights

Objective

To determine whether the Office of Mental Health is complying with the requirements established under Jonathan's Law. This audit covers the period April 1, 2015 through January 9, 2019.

About the Program

In February 2007, Jonathan Carey, a 13-year-old non-verbal autistic and developmentally disabled boy, died while in the care of a State facility operated by the Office of Mental Retardation and Developmental Disabilities (subsequently renamed the Office for People With Developmental Disabilities). Jonathan's parents attempted multiple times to obtain information concerning several unexplained injuries, unauthorized changes in treatment, and suspected abuse and neglect while at a privately operated facility and then at a State-operated facility. In May 2007, "Jonathan's Law" was enacted to expand parents', guardians', and other qualified persons' access to records relating to incidents involving family members residing in facilities operated, licensed, or certified by the Office for People With Developmental Disabilities, the Office of Mental Health (OMH), or the Office of Alcoholism and Substance Abuse Services. Under Jonathan's Law, facility directors are required to do the following in response to any incident involving a patient receiving care and treatment:

- Provide telephone notification to a qualified person within 24 hours of the initial reporting of an incident;
- Upon request by a qualified person, promptly provide a copy of the written incident report;
- Offer to hold a meeting with a qualified person to further discuss the incident;
- Within 10 days, provide the qualified person with a written report on the actions taken to address the incident (Actions Taken Report).

In addition, upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents within 21 days of either the conclusion of the investigation or the written request, whichever is later.

OMH operates 24 psychiatric centers across the State and has oversight of over 650 licensed providers that operate one or more private facilities, hereafter collectively referred to as "Facilities," subject to Jonathan's Law requirements. To assist with its oversight duties, OMH developed the New York State Incident Management and Reporting System (NIMRS) for Facilities to record and report incidents to OMH's central office.

Key Findings

- OMH has not implemented processes to effectively monitor whether Facilities are complying with Jonathan's Law requirements. While Facilities have established practices for notifying qualified persons within 24 hours of initial reporting of incidents, 20 percent

of the incidents we reviewed (all involving children under the age of 18) lacked support that the required notification had been made. OMH does not use NIMRS to capture information related to Jonathan's Law compliance and cannot readily determine whether Facility officials are meeting the Law's requirements.

- OMH's interpretation of Jonathan's Law is that only a telephone notification within 24 hours of an incident is required. All actions beyond the phone call are triggered only by a request from a qualified person, including the offer by Facility directors to meet with qualified persons or to provide qualified persons with a written report on actions taken to address the incident within 10 days. OMH's interpretation puts the burden to obtain information on qualified persons, who may not always be aware of their rights to this information.
- We also found Facilities do not always provide all records to qualified persons when requested or are not providing them within 21 days of the request from the qualified person or the conclusion of the investigation, as required. Only 33 percent of 12 records we tested were provided within the 21-day time frame. In addition, each Facility provided different information – with some offering more detail than others – to qualified persons when fulfilling records requests. As a result, qualified persons may not be receiving all pertinent information on incidents affecting the well-being of their family members.

Key Recommendations

- Incorporate the reporting of actions taken to comply with Jonathan's Law into NIMRS to allow OMH to more readily track Facilities' efforts to meet requirements.
- Provide updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements – including clear and consistent implementation procedures – and require Facilities to implement them.

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

July 19, 2019

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

Dear Dr. Sullivan,

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

Following is a report of our audit of the Office of Mental Health entitled *Compliance With Jonathan's Law*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

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

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Abbreviation	Description	Identifier
Facility	Collectively includes psychiatric centers operated by the Office of Mental Health, as well as facilities operated by providers licensed by the Office of Mental Health	*Key Term*
Justice Center	New York State Justice Center for the Protection of People with Special Needs	*Agency*
NIMRS	New York State Incident Management and Reporting System	*Information System*
OASAS	Office of Alcoholism and Substance Abuse Services	*Agency*
OMH	Office of Mental Health	*Auditee*
OPWDD	Office for People With Developmental Disabilities	*Agency*

Background

In February 2007, Jonathan Carey, a 13-year-old non-verbal autistic and developmentally disabled boy, died while in the care of a State facility operated by the Office of Mental Retardation and Developmental Disabilities (subsequently renamed the Office for People With Developmental Disabilities). Before Jonathan's tragic death, his parents attempted multiple times to obtain information concerning several unexplained injuries, unauthorized changes in treatment, and suspected abuse and neglect while residing initially at a privately operated facility, and then at a State-operated facility. Jonathan's passing and the lack of transparency in his care underscored the need for parents and guardians to receive timely information about incidents affecting the well-being of family members in such facilities.

In May 2007, legislation was enacted in New York State amending the Mental Hygiene Law. Known as "Jonathan's Law," these amendments were intended to expand access of parents, guardians, and other qualified persons to records relating to injuries and allegations of abuse or mistreatment (i.e., incidents) involving family members residing in facilities operated, licensed, or certified by the Office for People With Developmental Disabilities (OPWDD), the Office of Mental Health (OMH), or the Office of Alcoholism and Substance Abuse Services (OASAS). Adult patients can often be their own qualified persons entitled to rights under Jonathan's Law; children can't act as their own qualified persons.

A qualified person is defined under Section 33.16 of the Mental Hygiene Law to include:

- ***Patient/client***
- ***Legal guardian of a patient***
- ***Parents***
- ***Spouses***
- ***Adult children***
- ***Adult siblings***

Under Jonathan's Law, facility directors are required to do the following in response to any incident involving a patient receiving care and treatment at a facility:

- Provide telephone notification to a qualified person within 24 hours of the initial reporting of an incident;
- Upon request by a qualified person, promptly provide a copy of the written incident report;
- Offer to hold a meeting with a qualified person to further discuss the incident;
- Within 10 days, provide the qualified person with a written report on the actions taken to address the incident (Actions Taken Report).

Upon written request to the provider, qualified persons may obtain records and documents related to reportable incidents within 21 days of the conclusion of the investigation or the request from the qualified person,

whichever is later. For the purposes of Jonathan's Law, a reportable incident involves abuse (physical, sexual, or psychological) or neglect, but may also include incidents other than abuse or neglect that result in or have the potential to result in harm to the health, safety, or welfare of a patient. Furthermore, qualified persons may have access to additional information pertaining to allegations and investigations of abuse and mistreatment, including complaints and reports made pursuant to Article 11 of the Social Services Law to the New York State Justice Center (Justice Center).

New York State has a large, multi-faceted mental health system that serves more than 700,000 individuals each year. While Jonathan's Law also applies to facilities operated and licensed by OPWDD and OASAS, this audit focused only on facilities operated and licensed by OMH. Unlicensed providers, including supported housing, managed care, health homes, and waiver programs, are not subject to Jonathan's Law requirements.

OMH's mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances. OMH operates 24 psychiatric centers across the State (State-operated) and has oversight of more than 650 licensed providers (licensed providers) that operate one or more private facilities, hereafter referred to collectively as "Facilities," subject to Jonathan's Law requirements.

OMH developed the New York State Incident Management and Reporting System (NIMRS) for Facilities to record and report incidents to OMH's central office. Once incidents are logged into NIMRS, OMH officials may view the information. According to NIMRS data, from April 1, 2015 through August 22, 2018, Facilities reported more than 49,000 unique Jonathan's Law-applicable incidents involving more than 53,900 patients. Of the 53,900 patients, 8,465 were children involved in 7,511 unique incidents.

Audit Findings and Recommendations

OMH has not implemented processes to effectively monitor whether Facilities are complying with Jonathan's Law requirements. While Facilities have established practices for notifying qualified persons within 24 hours of initial incident reports, 20 percent (42 incidents) of the 210 incidents we reviewed lacked support that the required notification had been made. Furthermore, all but one Facility required qualified persons to request the Actions Taken Report before providing it, rather than automatically providing it.

OMH does not centrally capture information about Jonathan's Law compliance in NIMRS or otherwise, and cannot readily determine whether Facility officials are meeting the Law's requirements. Using NIMRS to capture key actions taken in response to incidents, such as noting when or if qualified persons were notified, would allow OMH to more easily track Jonathan's Law compliance across all Facilities.

Additionally, OMH's interpretation of Jonathan's Law is that all actions beyond the telephone notification within 24 hours of an incident are triggered only by a request from a qualified person. OMH's interpretation puts the burden to obtain information on qualified persons, who may or may not be aware of their rights to this information. As OMH did not instruct Facilities to offer a meeting or provide the Actions Taken Report unless requested, we found this was not being routinely done at any of the Facilities we visited.

We also found that Facilities are not always providing records to qualified persons when requested or are not providing them within 21 days of the later of the conclusion of the investigation or the written request, as required. Only 33 percent of the 12 records we tested were provided within 21 days. In addition, when fulfilling records requests, each Facility provided different information to qualified persons. Although OMH directs Facilities to include incident reports, summaries of initial responses, and investigative reports when qualified persons request records, one of the Facilities (State-operated) we visited was not including all this information in response to records requests. OMH does not closely monitor Facilities, especially licensed provider facilities, to determine what records they are providing when requests are made. As a result, qualified persons may not be receiving all pertinent information on incidents affecting the well-being of their family members.

Compliance With Jonathan's Law Requirements

Notification and Actions Taken Reports

We visited eight Facilities (four State-operated and four operated by licensed providers) and reviewed documentation for 210 incidents involving 266 clients

for evidence to support that qualified persons were notified within 24 hours via telephone of incidents involving family members. Our sample focused on children under the age of 18 who could not act as their own qualified persons. We found:

- 42 incidents (20 percent) involving 61 children (23 percent) had no evidence to support a telephone notification had been made to the qualified persons within 24 hours; and
- 4 Facilities (two State-operated and two operated by licensed providers) were unable to locate documentation for 18 incidents (9 percent) involving 19 children (7 percent).

Furthermore, only one of the eight Facilities we visited proactively provided (without the request) Actions Taken Reports for incidents involving abuse or neglect. However, this Facility did not proactively provide these reports for other incidents that still may or potentially have resulted in harm to the health, safety, or welfare of the patient. Additionally, in some instances, even when qualified persons requested the Actions Taken Reports (or it was the policy of the Facility to provide them), they were not always provided.

NIMRS could be used to capture information relevant to Jonathan's Law compliance, but OMH does not use it for this purpose. OMH can't readily determine whether Facility officials are meeting Jonathan's Law requirements. Capturing key actions related to incident response, such as noting when or if qualified persons had been notified, would allow OMH to more readily track Jonathan's Law compliance across all Facilities.

Offer to Meet With Qualified Persons

OMH's interpretation of Jonathan's Law is that all actions beyond the telephone notification within 24 hours of an incident are triggered only by a request from a qualified person. However, certain actions (such as the Facility director or designee offering a meeting and providing an Actions Taken Report to qualified persons) are not dependent on requests. OMH's interpretation of the Law potentially hinders access by qualified persons to pertinent information concerning the treatment of their family members. This interpretation puts the burden to obtain information on qualified persons, who may or may not be aware of their rights to this information. Further, OMH's guidance, provided as part of an informational package to family members, has not been updated to include adult siblings as qualified persons – a change that went into effect in 2017.

OMH did not instruct Facilities to offer meetings or provide the Actions Taken Report unless requested, and therefore, we found they are not doing so.

None of the Facilities offered qualified persons an opportunity to meet with the Facility director or designee at the time of the reporting of an incident. Instead, Facility officials expressed to us that they have an "open door policy" that allows qualified persons to meet with them at any time and for any reason (not just concerning Jonathan's Law incidents) and are in frequent communication with qualified persons, although the communications are generally not documented. One Facility's policy was to offer a meeting with the qualified person only once the investigation into the incident had been completed. However, at the time of our site visit to this Facility, officials stated they were in the process of changing this policy to allow for meetings with qualified persons at any time, provided the discussion did not interfere with, or delve into, an ongoing investigation. Another Facility also stated it expects its policies and practices would change to include both the issuance of an Actions Taken Report within 10 days of the incident and the offer to meet with qualified persons to further discuss the incident.

Release of Investigative Records

We found that Facilities are not always providing all records to qualified persons when requested or are not providing them within 21 days of the request from the qualified person or of the conclusion of the investigation, as required. Four of the eight Facilities we visited received requests for the release of records under Jonathan's Law. In total, qualified persons made 12 requests for the release of records, with 7 requested from one Facility (State-operated). Four of the 12 (33 percent) were provided within the 21-day time frame; 3 others (25 percent) were provided about a month after the request, or the date they were provided could not be determined. For the remaining 5 requests (42 percent), officials at two Facilities (both State-operated) couldn't provide information about when, or if, the requests had been fulfilled.

In addition, each Facility provided different information to qualified persons in response to the records requests. OMH directs Facilities to include incident reports, summaries of initial responses, and investigative reports in response to records requests by qualified persons. Also, the Justice Center is responsible for investigating allegations of abuse and neglect at Facilities and for issuing reports on the results. Facilities should provide these investigative reports issued by the Justice Center when fulfilling records requests by qualified persons. However, one of the Facilities we visited (State-operated) was not including Justice Center information when fulfilling records requests. OMH does not closely monitor Facilities, especially licensed provider facilities, to determine what records they are providing when requests are made, and NIMRS does not capture this information. We also found that not all officials were providing these reports in response to records requests, as required. As

a result, qualified persons may not be receiving all pertinent information on incidents that affect the well-being of their family members.

Recommendations

1. Incorporate the reporting of actions taken to comply with Jonathan's Law into NIMRS to allow OMH to more readily track Facilities' efforts to meet requirements.

2. Provide updated guidance to Facilities on their responsibilities related to Jonathan's Law requirements – clear and consistent implementation procedures – and require Facilities to implement them.

Audit Scope, Objective, and Methodology

Our audit objective was to determine whether OMH is complying with the requirements established under Jonathan's Law. The audit covers the period April 1, 2015 through January 9, 2019.

To achieve our audit objective, we interviewed officials from Facilities and reviewed and gained an understanding of Jonathan's Law, OMH regulations, and selected Facilities' policies and procedures related to Jonathan's Law compliance. We became familiar with, and assessed the adequacy of, internal controls related to OMH's oversight of Facilities' compliance with the requirements of Jonathan's Law.

We obtained and analyzed incident and provider data from NIMRS for the period April 1, 2015 to August 22, 2018 to determine the reliability and accuracy of the data. Overall, we determined the data to be reliable for the purposes of our audit objective. Furthermore, we reviewed actual incident-related data and documentation at selected Facilities as support for our audit findings.

We judgmentally selected 8 of 525 Facilities to determine compliance with Jonathan's Law. We based our selection on high frequency of serious incidents by incident type (e.g., abuse or neglect) and incidents involving only service recipients under the age of 18. For 7 of 8 Facilities, we pulled attribute samples using a systematic selection process based on dividing the total sample size by the total population of incidents for each Facility to determine a selection interval. We then applied that selection interval to the population of incidents. For the other Facility, we selected a block sample – selecting sequential incidents for each year in 2015 through 2018 based on reported date – due to the low number of incidents during the audit scope. In total, we selected and reviewed 210 incidents involving 266 clients out of 7,511 incidents and 8,465 clients. The results of our samples cannot be projected to the population as a whole.

Statutory Requirements

Authority

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

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

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to OMH officials for their review and formal comment. We considered their comments in preparing this final report, and they are attached to the end of it. Although OMH disagrees with our conclusions on the Facilities' obligations to offer a meeting and provide Actions Taken Reports to qualified persons, it responded that it plans to implement our recommendations. Our rejoinders to OMH's comments are embedded within their response.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Office of Mental Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and its fiscal committees, advising what steps were taken to implement the recommendations contained herein, and if the recommendations were not implemented, the reasons why.

Agency Comments and State Comptroller's Comments

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

CHRISTOPHER TAVELLA, Ph.D.
Executive Deputy Commissioner

June 10, 2019

Stephen Goss, CIA, CGFM
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Mr. Goss:

The Office of Mental Health has reviewed the Office of the State Comptroller's (OSC's) draft audit report entitled, "Compliance with Jonathan's Law" (2018-S-22). Our responses to the recommendations contained in OSC's report are enclosed.

Sincerely yours,

Christopher Tavella, Ph.D.
Executive Deputy Commissioner

44 Holland Avenue, Albany NY 12229 | omh.ny.gov

OFFICE OF MENTAL HEALTH
RESPONSE TO OFFICE OF THE STATE COMPTROLLER
DRAFT REPORT 2018-S-22
COMPLIANCE WITH JONATHAN'S LAW

The Office of Mental Health (OMH) has reviewed the findings and recommendations in the Office of the State Comptroller's (OSC) draft report (2018-S-22) entitled "Compliance with Jonathan's Law". The purpose of the audit was to determine whether or not OMH is complying with the requirements established under Jonathan's Law.

Jonathan's Law was enacted in May 2007 and was intended to expand access of parents, guardians, and other qualified persons to records relating to injuries and allegations of abuse or mistreatment involving family members residing in facilities that are licensed or certified by the Office for People with Developmental Disabilities (OPWDD), OMH, or the Office of Alcoholism and Substance Abuse Services (OASAS).

I. OMH Overall Comments

OMH finds many of OSC's findings inaccurate as they are based on OSC's misreading of Mental Hygiene Law (MHL) 33.23 (Jonathan's Law).

MHL 33.23 requires the director of a State-operated facility or local provider to provide telephone notice to a qualified person(s) of accident or injury that affects the health or safety of a patient within 24 hours of the initial report of the incident.

MHL Section 33.23 further provides that after the 24-hour notification of the incident has been made, upon the request of the qualified person, the facility director must provide a copy of the written incident report and offer to hold a meeting with the qualified person to further discuss the incident. The director must also provide a written report within 10 days on actions taken to address the incident.

Specific implementation procedures are not included in the law and OMH has followed the language of the law in applying the statute. OMH facility director's obligations to offer a meeting does not commence when the facility director contacts the qualified person, that obligation is triggered when the qualified person requests a copy of the written report. If the qualified person requests a copy of the report, the director should offer to meet with the person and also provide a written copy of the incident report.

OSC misinterprets the statute to read that the director is obligated to offer a meeting and provide a written report to the qualified person, even when this request is not initiated by the qualified person.

State Comptroller's Comment 1 – Facilities' obligation to offer a meeting and to provide a copy of the Actions Taken Report is not expressly contingent upon a request from a qualified person. This interpretation is consistent with guidance issued by the Justice Center (Jonathan's Law Incident Notification and Records Access), which Facilities have provided to qualified persons, and with regulations promulgated by OPWDD (New York Codes, Rules and Regulations, Title 14, Section 624.6). Additionally, by requiring qualified persons to request information beyond the telephone notification, OMH is putting the burden of seeking out additional incident information on the qualified person.

Additionally, although OSC defines the term "Facilities" as a combination of OMH operated psychiatric centers and State-licensed providers, OMH disagrees with the use of this term

as it is widely-known to describe State-operated psychiatric centers. During the closing conference on March 11, 2019, OMH expressed this concern to the audit team and the use of the term "programs" was discussed and agreed upon. However, OSC disregarded these comments when preparing the draft audit report.

State Comptroller's Comment 2 – We took OMH's concerns into consideration when writing the report. We used the term "Facility" because that is the term the Law uses to define places where relevant mental health services per the Law are provided. In several instances, we edited the report to clarify the wording referring to facilities as State operated or licensed provider operated. In addition, we specifically defined the difference between State-operated and licensed facilities, and noted whether our findings relate to State-operated or licensed provider facilities.

II. OMH Comments to OSC Audit Findings

1. **OSC's Interpretation of Jonathan's Law:** On page 6, third paragraph, OSC states, "Under Jonathan's Law, facility directors are required to do the following in response to any incident involving a patient receiving care and treatment at a facility: Provide telephone notification to a qualified person within 24 hours of the initial reporting of an incident; Upon request by a qualified person, promptly provide a copy of the written incident report; Offer to hold a meeting with a qualified person to further discuss the incident; Within 10 days, provide the qualified person with a written report on the actions taken to address the incident (Actions Taken Report)."

   OMH Comments: This is inaccurate. As noted above, OSC has misinterpreted Jonathan's Law. Contrary to OSC's interpretation, the statute clearly articulates that the obligation to offer a meeting does not commence when the facility director contacts the qualified person. This obligation is triggered when the qualified person requests a copy of the written report. Similarly, the law states that the Actions Taken Report only needs to be provided when requested.

   State Comptroller's Comment 3 – Please see State Comptroller's Comment #1.

2. **Inclusion of Adult Siblings as a Qualified Person:** On page 6, OSC includes the definition of a qualified person. It is noted that a qualified person includes: patient/client; legal guardian of patient; spouses, adult children; and adult siblings.

   OMH Comments: The legislation referred to as Jonathan's Law was passed in 2007 and adult siblings were not included in the list of qualified persons until 2017.

   State Comptroller's Comment 4 – We agree Jonathan's Law was amended in 2017 to include adult siblings, as we noted on page 9 of the report.

3. **OSC's Assumption that an Actions Taken Report Should be Automatically Provided:** On page 8, first paragraph, OSC states that "all but one Facility required qualified persons to request the Actions Taken Report before providing it, rather than automatically providing it."

   OMH Comments: MHL 33.23 states that the written report (Actions Taken Report) is only required to be provided upon a request from a qualified person.

   State Comptroller's Comment 5 – Please see State Comptroller's Comment #1.

4. **OSC's Erroneous Conclusion that Facilities Do Not Inform Qualified Persons of their Rights to Information:** On page 8, third paragraph, OSC states that beyond the telephone

notification within 24 hours of an incident, that all other actions are triggered only by a request from a qualified person. They further state that "OMH's interpretation puts the burden to obtain information on qualified persons, who may or may not be aware of their rights to this information".

OMH Comments: While OMH recognizes the opportunity to improve practice in this area by standardizing documents to be provided, it is incorrect to state that OMH puts the burden on the qualified person, as OMH is following the statute. Furthermore, during the admission process, information and documentation is provided to families regarding all of their rights to information, which includes those rights and documents associated with Jonathan's Law.

State Comptroller's Comment 6 – Please see State Comptroller's Comment #1.

5. **OSC's Assumption that OMH Should be Monitoring Facilities Regarding Jonathan's Law Compliance:** OSC stated on page 8, fourth paragraph, that "OMH does not closely monitor Facilities, especially licensed providers, to determine what records they are providing when requests are made."

   OMH Comments: It is not OMH's responsibility to monitor licensed providers compliance with Jonathan's Law. Since OMH-licensed providers are not operated by OMH, it is the responsibility of those providers to ensure compliance with laws and regulations (including those associated with Jonathan's Law).

   State Comptroller's Comment 7 – Pursuant to Article 31 of the Mental Hygiene Law, OMH has the authority and responsibility to set standards for the quality and adequacy of facilities and programs that provide mental health services and treatment. Additionally, Section 31.11 of the Mental Hygiene Law requires licensed providers to permit OMH to inspect the facility, including all records and reports – which would include records on compliance with Jonathan's Law.

6. **OSC's Assumption that an Actions Taken Report Should be Automatically Provided:** On page 9, second paragraph, OSC states that "only one of the eight Facilities we visited proactively provided Actions Taken Reports without the request".

   OMH Comments: As OMH has repeatedly stated, the law states that the Actions Taken Report is only required to be provided upon a request from a qualified person.

   State Comptroller's Comment 8 – Please see State Comptroller's Comment #1.

7. **OSC's Erroneous Conclusion that NIMRS Could Easily Track Information Associated with Jonathan's Law:** On page 9, third paragraph, OSC stated that "NIMRS could be used to capture information relevant to Jonathan's Law compliance, but OMH does not use it for this purpose."

   OMH Comments: NIMRS does not include the functionality to easily capture this information. However, OMH is undergoing a rewrite of the software and will review the feasibility of adding this capability. The completion of the rewrite is not expected until 2022.

   State Comptroller's Comment 9 – We are pleased OMH is taking steps to improve the functionality of NIMRS to capture Jonathan's Law information.

8. **OSC's Incorrect Interpretation of Jonathan's Law and their Erroneous Conclusion that Facilities Do Not Inform Qualified Persons of their Rights to Information:** OSC states on page 9, fourth paragraph, that certain actions (e.g., offering a meeting and providing an Actions Taken Report) are not dependent on requests. They further state that "OMH's interpretation of the Law potentially hinders access by qualified persons to pertinent

information concerning the treatment of their family members" and goes on to state that "this interpretation puts the burden to obtain information on qualified persons, who may or may not be aware of their rights to this information".

OMH Comments: This is inaccurate. As noted above, OSC has misinterpreted Jonathan's Law. Contrary to OSC's interpretation, the statute clearly articulates that the obligation to offer a meeting does not commence when the facility director contacts the qualified person. This obligation is triggered when the qualified person asks for a copy of the written report. The law also states that the Actions Taken Report only needs to be provided when requested.

Moreover, OMH does not put the burden on the qualified person. During the admission process information is shared with the family about all of their rights, which includes those associated with Jonathan's Law.

State Comptroller's Comment 10 – Please see State Comptroller's Comment #1. Additionally, while OMH may provide Jonathan's Law information during admission, not all qualified persons are necessarily present during the admissions process, furthering the importance of offering – without request – to discuss, and to provide an Actions Taken Report for, incidents involving qualified persons' family members.

9. **OSC's Assumptions Regarding Program Performance:** OSC states on page 9, fifth paragraph, that "OMH's guidance has not been updated to include adult siblings as qualified persons – a change that went into effect in 2017".

   OMH Comments: Although OMH's guidance had not yet been updated to include adult siblings, it was noted by the OSC auditors during the closing conference that they had not identified any instances where qualified adult siblings had been denied records.

   State Comptroller's Comment 11 – We agree and did not report any instances of denial of records requests by qualified siblings. However, OMH's guidance should be updated so that adult siblings are clear regarding their rights under Jonathan's Law.

10. **OSC's Assumption that Communications with Qualified Persons are Not Documented:** On page 10, first paragraph, OSC inaccurately draws the conclusions that communications with qualified persons are generally not documented.

    OMH Comments: OSC reviewed 210 of 8,465 incidents (2 percent) that occurred at 8 out of 525 programs (1 percent). While OMH agrees that documentation may not be systematic in nature, it is unfair to make this conclusion based on a few hours on-site at each location reviewing only 2 percent of the incidents that occurred.

    State Comptroller's Comment 12 – Our report is clear that this observation only applies to the Facilities we visited. Furthermore, the report states that we selected our sample to review only incidents involving children, and we disclose that the results cannot be projected across the population. However, given the instances of non-compliance found in our sample, we believe the deficiencies warrant further attention and review by OMH.

11. **OSC's Erroneous Conclusion that OMH Should Provide Qualified Persons with Justice Center Investigative Reports:** OSC inaccurately draws the conclusion on page 10, third paragraph, that "Facilities should provide these investigative reports issued by the Justice Center when fulfilling records requests by qualified persons".

    OMH Comments: OMH is of the position that these reports belong to the Justice Center

and therefore they should be the ones to distribute their reports to the qualified person. The Justice Center disagrees with that position. OMH and the Justice Center are currently in discussions to resolve this and determine the most effective way in which the results of investigations performed by the Justice Center are transmitted to a qualified person.

State Comptroller's Comment 13 – Jonathan's Law does not apply to the Justice Center, and the responsibility to provide records is therefore placed on the Facility. We are pleased OMH is working with the Justice Center to determine how to most effectively provide this information to qualified persons.

III. OMH Responses to OSC Recommendations

- **OSC Recommendation No. 1 – Using NIMRS to Track Actions Taken**
  Incorporate the reporting of actions taken to comply with Jonathan's Law into NIMRS to allow OMH to more readily track facility efforts to meet requirements.

  OMH Response
  NIMRS does not currently have this functionality. OMH will consider this recommendation as there is currently a rewrite underway for the modernization of NIMRS. However, completion of the new program is not expected until 2022.

- **OSC Recommendation No. 2 – Guidance Associated with Jonathan's Law.**
  Provide updated guidance to facilities on their responsibilities related to Jonathan's Law requirements – clear and consistent implementation procedures – and require facilities to implement them.

  OMH Response
  OMH agrees with this recommendation and will review and update all guidance as it pertains to Jonathan's Law, and re-distribute to programs as appropriate.

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