A Forensic Manual
For
Directors of Community Services

A Technical Assistance Project
Prepared for the
New York State Conference of Local Mental Hygiene Directors, Inc.
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## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>NYS Mental Hygiene Law</strong></td>
<td>5</td>
</tr>
<tr>
<td>Emergencies in the Community</td>
<td>5</td>
</tr>
<tr>
<td>MHL §9.41 – Powers of Law Enforcement</td>
<td>5</td>
</tr>
<tr>
<td>MHL §22.09 – Emergency Services; Incapacitated by Substances</td>
<td>7</td>
</tr>
<tr>
<td>MHL §9.45 – Powers of Directors of Community Services</td>
<td>9</td>
</tr>
<tr>
<td>MHL §9.43 – Powers of Courts</td>
<td>11</td>
</tr>
<tr>
<td>Other Emergency Statutes Used in Transporting Individuals</td>
<td>13</td>
</tr>
<tr>
<td>MHL §9.55 – Powers of Qualified Psychiatrists</td>
<td>13</td>
</tr>
<tr>
<td>MHL §9.57 – Powers of Emergency Room Physicians</td>
<td>14</td>
</tr>
<tr>
<td>Hospital Admissions</td>
<td>15</td>
</tr>
<tr>
<td>MHL §9.39 – Emergency Admissions</td>
<td>15</td>
</tr>
<tr>
<td>MHL §9.27 - Involuntary Admission on Medical Certification</td>
<td>17</td>
</tr>
<tr>
<td>MHL §9.37 – Admission on Certificate of a DCS or Designee</td>
<td>18</td>
</tr>
<tr>
<td>Assisted Outpatient Treatment (MHL § 9.60)</td>
<td>19</td>
</tr>
<tr>
<td><strong>NYS Correction Law</strong></td>
<td>24</td>
</tr>
<tr>
<td>Hospital Admissions of Incarcerated Individuals</td>
<td>24</td>
</tr>
<tr>
<td>CL §508 – Removal of Sick Prisoners from Jail</td>
<td>25</td>
</tr>
<tr>
<td>CL §402 – Commitment of Mentally Ill Inmates</td>
<td>26</td>
</tr>
</tbody>
</table>
NYS CRIMINAL PROCEDURE LAW .................................................................27
  CPL §730 –
  Mental Disease or Defect Excluding Fitness to Proceed ..................27
  CPL §390.30 – Scope of Pre-sentence Investigation and Report .......32
  CPL §250.10 – Examination of Defendant .....................................33
  CPL §330.20 – Procedure following Verdict or Plea of Not
  Responsible by Reason of Mental Disease or Defect ....................34

SPECIAL ISSUES

  JUVENILES ..........................................................................................37
  CONFIDENTIALITY & PRIVACY .........................................................39
  PROBLEM-SOLVING COURTS ..............................................................39

FREQUENTLY ASKED QUESTIONS ..........................................................41

APPENDICES

  Appendix 1 - Examples of Police Transport Forms (MHL §9.41)
  Appendix 2 - Overview of Police Mental Health Training
  Appendix 3 - Sample Policy & Procedure for Appointment of DCS
                Designees / MOU for DCS Designees
  Appendix 4 - Competency Process and Measures
                Lean Six Sigma Project to Reduce 730 Bed Utilization
  Appendix 5 - Releasing Individuals from Custody for the Purpose of
                Hospitalization
Introduction

The purpose of this Director of Community Services-oriented reference is to provide guidance on a wide range of issues with which County Directors need to be familiar, particularly those that arise when individuals with mental illness come into contact with law enforcement or other aspects of the criminal justice system.

The manual is organized by the relevant sections of law. Pertinent sections from NYS Mental Hygiene Law (MHL) are presented first followed by sections from NYS Correction Law (CL) and NYS Criminal Procedure Law (CPL). The “Special Issues” section contains brief explanations about Juveniles, Confidentiality, and Problem-Solving Courts. Frequently Asked Questions (FAQs) is the final section before the appendices that contain supplementary information. Hyperlinks are provided to the specific sections of the law that are addressed as well as other resources that are mentioned.

Each specific section begins with a brief summary of that area of the law. After a general overview of a specific statute, the following topics are addressed: transportation, documentation, cost, outcome, and the role of the DCS.

For ease of use, the individual listings in the Table of Contents are linked directly to each section in the manual (and therefore clicking on a section or a specific law will bring you directly to that part of the manual).

Please note that this manual presents summaries of pertinent sections of law. It is not intended to replace reading specific legal statutes. Moreover, county-specific practices may supersede some of the operational details outlined in the manual. Finally, the information contained in this manual is not intended to replace consultation with your county attorney.
NYS MENTAL HYGIENE LAW

NYS Mental Hygiene Law (MHL) governs various aspects of the mental health, chemical dependency, and the developmental disability service systems. Of particular relevance to this Manual are sections of the law that direct how individuals can be brought to a hospital against their will and subsequently admitted to an inpatient service. The sections below detail the four ways in which people in the community can be brought to the hospital (via Mental Hygiene Law), two additional mechanisms to transfer individuals from one treatment setting to another, three involuntary admission statuses, and New York’s outpatient commitment statute (Kendra’s Law).

Emergencies in the Community (§9.41; §22.09; §9.45; §9.43)

Individuals experiencing mental health crises in the community may require intervention to ensure that they remain safe and that their mental health needs are thoroughly assessed. Law enforcement is often involved in making a determination that an involuntary transport to the hospital is necessary for further evaluation (pursuant to Mental Hygiene Law §9.41 and §22.09) or in acting upon the request of Director of Community Services or his or her designee (§9.45) to have someone brought to the hospital for further evaluation. The other statute that is relevant to this discussion is §9.43, which outlines how, under certain circumstances, judges can order someone to be brought to a hospital for evaluation.

While three of these sections of the law (§9.41, §9.43, and §9.45) have titles that begin with “Emergency admissions for immediate observation, care, and treatment,” in fact all of these statutes are about getting someone to a hospital for an evaluation for possible admission and do not address any aspect of the inpatient admission process. Section §22.09 is more accurately entitled (“Emergency Services for persons intoxicated, impaired, or incapacitated by alcohol and/or substances”).

The specifics of these four sections of the law are delineated below.

MHL §9.41 – Powers of Law Enforcement

- An individual must meet two criteria in order for law enforcement to have the power to bring the person to the hospital against their will:
  1. The person must appear to be mentally ill, and
  2. The person must present in a manner that is likely to result in serious harm to the person or others. This standard includes specific threats to self, others, or other conduct that demonstrates that the individual is unable to care for their basic needs for food, shelter, clothing or healthcare.
Please note that the criteria often get (inaccurately) summarized to be “when someone is either suicidal or homicidal.” First, it is necessary that the person “appear to be mentally ill.” Law enforcement personnel are trained to observe verbal, behavioral and environmental indicators of mental illness. It is not expected that police make a definitive determination that someone is mentally ill; they only need to make a judgment that the person appears to be mentally ill. Second, transport under §9.41 is permissible if the person is or is not imminently suicidal or homicidal (or otherwise threatening harm to self or others). Dangerousness not only includes suicidal and homicidal ideation or acts, but “other conduct that demonstrates the individual is unable to care for their basic needs for food, shelter, clothing or healthcare.”

- **Transportation:** Individuals who are transported under this section must be brought to either a hospital licensed and approved under section 9.39 or a Comprehensive Psychiatric Emergency Program (CPEP), or “another safe and comfortable place” while the hospital or CPEP examination is pending (in which case the DCS must be notified). Transportation is provided by either the law enforcement agency initiating the transport or an ambulance (per local agreements). Although it is not specified in the law, it is commonplace in many jurisdictions that law enforcement accompanies the ambulance to the hospital. This is suggested as a way to prevent adverse outcomes (e.g., individuals absconding once the ambulance reaches the hospital).

- **Documentation:** NYS OMH issued a form (Form OMH 474A/476A (7/09)) that can be used by law enforcement to document the §9.41 transport. Because this form provides no opportunity for law enforcement to document their observations and thus is minimally helpful to hospital personnel, some counties have worked with their local law enforcement agencies to develop a county “Mental Hygiene Transport Form” that incorporates the elements on the State form and provides more space for police to convey the elements of mental illness and dangerousness that they observed. **Appendix 1** includes examples of these forms from Monroe, Oneida, and Ulster Counties.

- **Cost:** This section of MHL does not address any financial issues. In jurisdictions where police directly transport individuals in their cars, it is considered part of their normal duties and there is no separate charge involved. When an ambulance is used, the transported individual is liable for the cost of the transport. Likewise, the person will also incur the cost of the emergency room visit and/or subsequent inpatient costs.

- **Outcome:** Once police decide that a person meets the criteria pursuant to MHL §9.41 the person is transported to a 9.39 hospital.
or a CPEP for evaluation (or “another safe and comfortable place,” as previously mentioned). Upon completion of an evaluation, the person is usually either admitted to an inpatient psychiatric unit or discharged. As an alternative, MHL §9.40 provides that the individual could be admitted to Comprehensive Psychiatric Emergency Program (CPEP) Extended Observation Bed (EOB) for a period of up to 72 hours. The EOBs, usually located in or adjacent to the emergency room, are used for further evaluation to decide whether an inpatient admission is warranted and for brief, time-limited interventions.

○ DCS Role: There is no direct role for the DCS or DCS designees under MHL §9.41; law enforcement are authorized to act independently. However, from time-to-time the DCS or other LGU staff may be called upon to mediate disputes between law enforcement and hospital personnel in terms of the appropriateness of §9.41 transports and/or the disposition decided upon by hospital staff. For example, it is not unusual for hospitals to complain that police bring individuals to the hospital that should have been transported directly to jail. Similarly, the police may complain that individuals who they believe to be seriously mentally ill are not admitted to an inpatient unit (and are released within a couple of hours of being brought to the emergency room). By arranging to have law enforcement and hospital personnel in the same room, a productive dialogue can take place where “each side” learns about the constraints and protocols of the other. Some counties have an ongoing forum that includes law enforcement, hospital personnel and others (e.g., EMS) to continuously address issues as they arise.

Some LGUs make themselves available (or arrange for their contracted providers) to provide training for local law enforcement on issues related to recognizing and intervening with citizens who appear to be mentally ill. Appendix 2 contains a brief overview of police mental health training that is mandated in NYS Police Academies, a one-day in-service curriculum for other officers, as well as other opportunities for police departments to develop more expertise in mental health-related areas.

MHL §22.09 - Emergency Services for those Incapacitated by Substances

- Individuals who are judged to be incapacitated due to intoxication or other substances to the degree that there is a likelihood of serious harm to the person or others can be brought to a hospital on an involuntary basis. The standard of “likelihood of serious harm” is the same as previously articulated in §9.41 above. However, it is important to note that there is no assumption of the presence of mental illness within §22.09. That is, there only needs to be evidence of intoxication/incapacitation and
dangerousness. Nevertheless, the presence of mental illness doesn’t “disqualify” an intoxicated person from being transported on an involuntary basis pursuant to §22.09. Likewise, the presence of intoxication doesn’t make someone ineligible for a §9.41 transport (or §9.45, to be discussed below).

- **Transportation** – Transportation to the hospital can be done via local law enforcement or ambulance, according to local agreements. The law allows for the DCS and Designees to transport, although given liability and other practical considerations, it is unlikely that many counties do this. The law requires that the DCS, DCS designee, or law enforcement officer accompany the individual to the hospital. Please note that individuals can be brought to a general hospital under §22.09, not just 9.39 hospitals (as is the case under §9.41 and §9.45).

- **Documentation**: There is no separate §22.09 form issued by the State. Some jurisdictions have a place on their county form (discussed above in §9.41) where law enforcement indicate “22.09” as opposed to “9.41.”

- **Cost**: Similar to §9.41, there is no direct discussion of fiscal issues in this section of MHL. Costs are borne either by the police department involved in conducting the transport, or the transported individual if an ambulance is used. The person will also be liable for any costs related to the evaluation at the hospital.

- **Outcome**: Hospitals are allowed to involuntarily detain an individual brought to the hospital under §22.09 until they are “no longer incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or others,” but in no case for more than 48 hours. The transported individual may be referred for inpatient de-tox or rehabilitation but there is no mechanism in the statute for involuntary chemical dependency treatment. Thus, any follow-up treatment to address chemical dependency issues needs to be agreed upon by the client. Of course, involvement in the criminal justice system affords some opportunities for “legal leverage” to encourage compliance with recommended treatment. For example, if someone is on Probation, a condition of Probation can be to follow-up with any recommended chemical dependency (and mental health) treatment.

- **DCS Role**: The DCS (as well as a DCS designee) is authorized, pursuant to MHL §22.09, to take someone who meets the above referenced criteria to a “general hospital or any other place authorized by the commissioner in regulations...” Please note that there is no language in §22.09 that authorizes the DCS (or Designees) to direct law enforcement to transport (or arrange for
transport) to a hospital, as there is in §9.45 detailed below. Therefore, although DCS designees can initiate §22.09s, it is unclear to what extent that happens.

MHL §9.45 – Powers of Directors of Community Services (& Designees)

- This section provides a Director of Community Services (DCS) the authority to direct the removal of a person to a 9.39 hospital or a CPEP. The DCS may appoint “Director of Community Services Designees” (DCS Designees) to act on his or her behalf. Similar to MHL §9.41, this section requires evidence of mental illness and an element of dangerousness to the point that hospitalization may be warranted. As detailed in the law (and on Form OMH 474A/476A (7/09)) the DCS or DCS Designee can initiate the process based on the request of any one of a number of authorized reporters who state that the person has a mental illness for which immediate hospitalization is warranted. These include: a licensed physician, a licensed psychologist, registered professional nurse, or certified social worker currently responsible for providing treatment services to the person, a peace or police officer, the spouse of the person, the child of the person, the parent of the person, the adult sibling of the person, the committee or legal guardian of the person, the supportive or intensive case manager of the person or a “health officer” (appointed pursuant to Section 320 of the Public Health Law).

Note that under §9.41 the standard is that the person must “appear” to have a mental illness. Under §9.45 the reporter must state that the person “has a mental illness.” While this makes sense in that the Director of Community Services or clinicians who are DCS designees are initiating a §9.45 and thus confirming the presence of a mental illness, in practice there is little distinction made between the standards for law enforcement initiated §9.41s and DCS designee initiated §9.45s.

It is important to note that law enforcement officers are obligated to act on a properly executed §9.45 application (i.e., one filled out by a DCS or DCS designee). The law states that the DCS or his/her designee has “the power to direct the removal of any person” who meets the previously specified criteria. There are times that law enforcement will judge an individual to not meet the §9.41 criteria when they are dispatched to facilitate a transport pursuant to §9.45; that is irrelevant. A §9.45 is similar to a court-order or an arrest warrant in that police are obligated to bring the person to the 9.39 hospital emergency room.

Please note that individuals who are appointed DCS designees are authorized to act on behalf of the Director of Community Services only for the specific county in which they were appointed. Therefore, even if all the criteria are met for a §9.45 (i.e., information received from an authorized reporter indicating the person has a mental illness and meets the
dangerousness criteria), if the person is not within the County, the §9.45 order cannot be issued. In those rare circumstances, two courses of action are suggested. A direct call to the DCS in the other county to advise him/her of the situation is advisable. In addition, some consideration should be given to calling law enforcement in the jurisdiction where the person is thought to be. Even without a §9.45 order issued, law enforcement should be willing to “check the welfare” of individuals reported to be in distress and/or potentially dangerous, and to initiate a §9.41 pick-up when indicated.

Please note that face-to-face evaluations by DCS designees are not required to complete the §9.45 process.

- **Transportation**: The law specifies that law enforcement have the duty to “take into custody and transport” individuals upon the direction of the DCS (or designee) that an individual meets the criteria set forth in §9.45. The law also states that “upon the request of a director of community services or the director’s designee” an ambulance service is authorized to transport and, in many jurisdictions, local agreements between law enforcement and EMS personnel exist whereby ambulance services are used frequently for such transports.

- **Documentation**: DCS designees document (by filling in Form OMH 474A/476A) that the person “has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to him/her or others.” The DCS or designee is required to specify the name and category of the person who reported the information. It is helpful if additional documentation is provided to hospital personnel that will help them understand the reasons why the §9.45 was initiated and will help in their assessment.

Please note that the state-issued §9.45 forms have undergone several revisions through the years, consistent with changes in the law. In particular, in 2006 the law was changed to allow Supportive Case Managers (SCMs) and Intensive Case Managers (ICMs) to be authorized reporters under 9.45. Unfortunately, many DCS designees have stacks of old forms that do not include this important revision. Updated forms can be obtained from the NYS OMH Print Shop. [Some have noted that the Print Shop website can be challenging to negotiate. By clicking the “on-line catalogue” button on the home page, and then entering in the form number you are seeking, in the case of §9.45s – it would be “474A/476A” – it will take you to the order page. You should receive the most updated forms, even though the visual representation of the §9.45 form on the website is outdated. Please note that there is no charge for
§9.45 forms, however shipping and handling charges are applied to orders.]

- **Cost**: Similar to §9.41 and §22.09, there is no mention in the law of the cost or payment mechanisms covering transportation to the hospital. However, a 1950 Comptroller’s opinion held that “local health officers” may use an ambulance service to transport individuals “to hospitals or other institutions before they are committed to State institutions” and that “expenses so incurred are county charges and should be paid on signature of judge or justice where case went to court or on signature of local health officer where case did not go to court.” (6 Op.State Compt. 279, 1950). At first glance it may appear that this could result in a significant financial burden for counties. As a practical matter, individuals transported by police officers do not incur charges and those transported by ambulance are billed for the costs of transport. If the client is enrolled in Medicaid, costs would be covered accordingly.

- **Outcome**: Similar to what was detailed above under §9.41, possible outcomes of those brought to the hospital under §9.45 include an inpatient admission, discharge, or, in the case of CPEPs, admission to an Extended Observation Bed.

- **DCS Role**: Although DCSs are authorized to initiate §9.45s, in many counties DCS designees are the ones that carry out the majority of §9.45s orders. Thus, an important role for the DCS is to decide who to designate as a “DCS designee.” The only definition of designee in MHL is in section 9.37 which refers to an examining physician and to the extent possible many LGUs designate psychiatrists working in their public system. Another guide would be to look to the qualifications for a DCS as set forth in 14 NYCRR Part 102.6. For example, the Monroe County appointment policy is based on these qualifications while Ontario County restricts designees to physicians. (Appendix 3 contains both the Monroe County Policy and the Memorandum of Understanding utilized by Ontario County.) Since the Designee will be making a determination that a person has a mental illness and is in need of involuntary transport to a hospital based on the report of another person, diligence and liability concerns would suggest that it is imperative that such designee have the clinical expertise and experience to make such decisions.

**MHL §9.43 – Powers of Courts**

- There are two separate provisions of §9.43; each provides a way for individuals to be brought to a 9.39 hospital or CPEP for evaluation. The first outlines a procedure to bring an individual (who has not been charged
with any crime) before a court, which, if appropriate, may issue a civil order that the individual be transported to a psychiatric emergency room for examination and possible admission. A 9.43 involuntary removal order is a civil order issued by a judge when he or she is presented with evidence that an individual has, or may have, a mental illness, and presents a danger to self or others. A §9.43 order may be requested of the court by a treating clinician or family member. This provision pre-dates the advent of the increase in mobile crisis teams and ACT teams across the state. These outreach teams, in conjunction with §9.45 powers (or in the case of mobile teams – $9.58$) are often used as more effective alternatives to addressing challenges in the community.

Under the second provision of §9.43, an order may be issued by a judge in criminal cases when the individual appearing before the judge appears to have a mental illness and presents a danger to self or others, and the court determines either that the crime has not been committed or that there is not sufficient cause to believe that such a person is guilty of the crime. In such cases, the court may order that the charge(s) presently before the court be dismissed and that the person be brought to a 9.39 hospital for evaluation. [Section §9.43(b)].

Although not specifically provided for in the statute, §9.43 orders have also been used at other times during court proceedings to send individuals to a hospital for evaluation without dismissing the charges. In summary, this disposition means that the criminal proceedings are either dismissed or adjourned. Use of §9.43 appears to vary widely across the state, based on local traditions and other alternatives available.

- **Transportation:** Per NYS MHL, individuals must be brought to a 9.39 hospital (or a CPEP). Given that individuals are transported from court, in most circumstances a local law enforcement agency will conduct the transport. However, if the individual's condition is such that an ambulance is preferred (or local agreements include the use of an ambulance), there is nothing specified in MHL to preclude that.

- **Documentation:** The Court is responsible for issuing the order that initiates the transport to the hospital. The State has issued a template (Form OMH 465) for these orders which jurisdictions may choose to use.

- **Cost:** Similar to sections of the law previously discussed ($9.41$, $9.45$ and $22.09$), there is no mention in MHL of the cost or payment mechanisms covering transportation to the hospital and thus, in most circumstances, the individual involved would be responsible for any costs associated with transportation, evaluation, and hospital admission. Additional support for the County not being held liable for costs is found in the "Notes of Decisions" where it...
says “A county is not liable for the costs incurred where a court issues a civil order pursuant to section directing that a person be removed to a hospital for a determination of mental illness” (Op. State Compt. 81-154).

- **Outcome**: As in the previous sections discussed, after an examination at the hospital, possible outcomes include discharge, admission, or an admission to an Extended Observation Bed (at CPEPs).

- **DCS Role**: Although there is no official role specified for the DCS, depending on the circumstances and/or local working relationships, you may be called upon to help address the current situation at hand. For instance, some judges not familiar with §9.43 may call the DCS seeking advice on how to resolve a particular situation. Upon hearing a description of the individual in court, you might have the occasion to suggest the judge initiate a transport to the hospital pursuant to §9.43. In these circumstances, it would be helpful to offer to provide the judge will a template for that order. Although it may seem more efficient for you to simply issue a §9.45 in those circumstances, please note that a judge is not an authorized reporter in §9.45 and thus, a §9.45 could not be initiated based solely on a judge’s report.

**Other Emergency Statutes Used in Transporting Individuals (§9.55; §9.57)**

In most, if not all counties, the vast majority of involuntary transports are accomplished via §9.41 and §9.45. However, the sections of MHL detailed below provide options for certain individuals who are not DCS designees.

**MHL §9.55 – Powers of Qualified Psychiatrists**

- This section of MHL allows psychiatrists (i.e., licensed physicians who are board certified or board eligible) who are supervising or providing treatment in a facility licensed or operated by NYS OMH which does not have an inpatient psychiatric service, to direct the removal of individuals to a 9.39 facility for evaluation for admission. The individual must meet the standard of having a mental illness and being dangerous to self or others (as previously described in §9.45). However, there is one significant difference between §9.45 and §9.55. Under §9.55 a face-to-face evaluation is required to be completed by the person (psychiatrist) filling out the form. As mentioned previously, the person filling out the §9.45 form (DCS designees including psychiatrists) are not required to have evaluated the person.

- **Transportation**: As in the other sections previously discussed (§9.45 & §9.41), transportation is done by local law enforcement and/or ambulance, according to local standards of practice.
o **Documentation**: The state-issued form (Form OMH 474A/476A (7/09)) that has the §9.45 on the front – has the §9.55 form on the back. (Please note that forms dated 6/06 and before have a typographical error in them; it specifies that the psychiatrist is supervising or providing treatment at a facility licensed and (emphasis added) operated by the Office of Mental Health which does not have an inpatient unit. More recent versions of the form have been corrected and read “…a facility licensed or operated by the Office of Mental Health…”)

o **Cost**: The person transported to the hospital is responsible for costs incurred by the ambulance (if used) and the evaluation conducted at the hospital.

o **Outcome**: Similar to other sections of MHL previously discussed, outcomes include discharge, inpatient admission, or admission to an Extended Observation Bed.

o **DCS Role**: There is no role for the DCS under §9.55.

**MHL §9.57 – Powers of Emergency Room Physicians**

- Emergency room physicians at a hospital that does not have an inpatient psychiatric service who judge someone to have a mental illness and is dangerous to self and/or others (in accordance with the §9.39 definition), can arrange for them to be brought to a 9.39 hospital for further evaluation. This section also covers CPEP physicians.

  o **Transportation**: Law enforcement and/or ambulance service transports.

  o **Documentation**: The state-issued form (Form OMH 474A/476A (7/09)) that has the §9.45 on the front – has the §9.57 form on the back. Note that it requires the signature of the examiner (attesting to an examination). It also requires the signature of a “Hospital Director/Designee.” Although the form is structured to imply that two separate individuals need to be involved, the law is vague in this regard and there are times that the emergency room physician is both the examiner and the designee of hospital director.

  o **Cost**: Not addressed in the law; individual who is transported will be responsible for any bills.

  o **Outcome**: Similar to other sections of MHL previously discussed, outcomes include discharge, inpatient admission, or admission to an Extended Observation Bed.
DCS Role: There is no role for the DCS under §9.57.

Hospital Admissions (§9.39; §9.37; §9.27)

There are several sections of Mental Hygiene Law that detail the criteria and process for psychiatric hospitalization. Commonly used statutes include §9.39, §9.37, and §9.27. These are all referred to as “involuntary admissions” – since the person does not have to consent to the hospitalization – as long as they are judged to meet the standard for hospitalization particular to each statute. In brief, the standard is that the person needs to be mentally ill and present some substantial risk of harm to self or others. This is sometimes inaccurately summarized to mean that the person needs to be “suicidal or homicidal.” If a person is judged to be a suicidal and/or homicidal risk in the context of mental illness, the criteria for involuntary hospitalization would likely be met. However, similar to the previous discussion regarding §9.41 and §9.45, there are other ways that a person can meet the criteria for involuntary hospitalization. For instance, a person could be so disabled due to their mental illness that they are unable to meet their basic needs for food, shelter, clothing or healthcare. In these circumstances, individuals can be judged to meet the criteria for involuntary hospitalization. (Even if individuals are admitted on a “voluntary status” (§9.13), they may held for up to 72 hours after requesting release to determine if further hospitalization is needed, and apply for a court order if it is.)

In addition to reviewing the specific statutes, Mental Hygiene Legal Services can be consulted regarding the specific process for someone to object to their involuntary detention within a psychiatric facility.

Regardless of how someone initially presents at a hospital (referred by their primary care physician or a mental health provider, brought by family or law enforcement, or walk-in on their own), emergency room personnel complete an evaluation to determine whether an inpatient admission is warranted.

Summaries of the three Involuntary Admission statutes are below.

MHL §9.39 – Emergency admissions for immediate observation, care and Treatment

- This section of MHL is used when an individual presents at the hospital meeting the criteria (described above) for an involuntary admission. It doesn’t matter whether the person was brought in by law enforcement or an ambulance (pursuant to §9.41 or §9.45), driven to the hospital by family or friends, or presents on their own.

  - Transportation: This section of MHL does not cover transportation issues; individuals admitted under this statute are already at the hospital.
o **Documentation:** A physician at a 9.39 hospital (i.e., a hospital approved by the Commissioner of Mental Health to receive and retain individuals according to this section of MHL) must fill out and sign the Emergency Admission (Form OMH 474).

Within 48 hours another examination must be completed by a psychiatrist confirming the continued for involuntary hospitalization. Please note the admitting physician does not need to be a psychiatrist. However, the Examination to Confirm Need for Extension of Emergency Admission Beyond 48 Hours needs to be completed by a psychiatrist.

o **Cost:** Although not specifically addressed in this section of MHL, the individual admitted to the hospital under this statute is responsible for the cost. Please keep in mind, however, that NYS OMH licensed programs need to serve those in need without regard to the ability to pay (although there is likely wide variation across the State in how hospitals adhere to this standard).

o **Outcome:** Once admitted to an inpatient unit pursuant to §9.39, several outcomes are possible. As alluded to above (under “documentation”), if a psychiatrist fails to confirm the need for continued stay (beyond 48 hours), the person will be discharged. If the need for continued stay is documented, then the person may remain hospitalized under §9.39 for up to 15 days. Within those 15 days, if it is determined the person is not in need of continued involuntary inpatient treatment, the person will be discharged, unless the person agrees to stay as a voluntary patient (pursuant to §9.13) and the treating psychiatrist determines that this is appropriate. If continued, involuntary treatment is needed, a two physician certificate (2 PC) needs to be completed (this is addressed in the next section).

If at any time during this process, the person who is hospitalized (or their family) objects to continued stay, a court hearing is scheduled within five days to address this issue.

o **DCS Role:** The DCS has no direct role in the admission process and/or the process of extending the inpatient stay, as detailed above. However, it is helpful for the DCS to be generally familiar with the laws and procedures governing this process, as it is not unusual for citizens who were subjected to involuntary hospitalization to call the LGU to complain and/or to ask for clarification about the roles of those involved. It is helpful for LGU staff to have the number of the regional Mental Hygiene Legal Service office to refer individuals who are calling from inpatient units looking for legal representation to contest their involuntary commitment.
MHL §9.27 - Involuntary admission on medical certification

- This is commonly referred to as a “2 PC,” or a two-physician certificate. This statute states that “the Director of a hospital may receive and retain therein as a 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 admission of such person.” No further admission criteria is specified in §9.27. However, the NYS OMH issued forms used to apply for and complete an admission pursuant to §9.27 state that in addition to needing involuntary care and treatment in a hospital, the person must pose “a substantial threat of harm to self or others…”

The 2 PC offers a mechanism for others (including family members, others with whom the person resides, the DCS, the director of a hospital where the person resides, a psychiatrist) to apply for admission for someone whom they believe is in need of involuntary care and treatment.

A 2 PC is also used to extend an involuntary inpatient admission stay beyond 15 days of someone initially admitted under §9.39. It can also be used to transfer someone from one hospital to another

  - **Transportation:** Law enforcement and/or an ambulance service are used to transport individuals to a psychiatric hospital under §9.27.

  - **Documentation:** The “Application for Admission” (Form OMH 471) is first filled out by an authorized individual that details why inpatient hospitalization is needed.

    Two physicians then need to examine the person alleged to be in need of hospitalization. Note that the examiners in this case do not need to be psychiatrists. The law states that the examination may be conducted jointly, but that each physician needs to document their findings separately (Certificate of Examining Physician; Form OMH 471A). Their documentation needs to provide a rationale as to why the person needs to be hospitalized (i.e., why hospitalization is essential to the person's welfare and how the person poses a substantial risk of harm to self or others).

    Prior to admission, a psychiatrist on the staff at the hospital where the person will be admitted needs to confirm that they have examined the person and that he or she, as a result of their mental illness, poses a substantial threat of harm to self or others.

All told, four separate individuals are needed to complete a 2 PC admission (an applicant and three physicians, including one psychiatrist).
Cost: The patient would be responsible for this emergency admission in the same manner as any other hospitalization.

Outcome: While the statute does not specify the length of time that someone may be kept on an inpatient unit on a §9.27 status, the first page of the forms promulgated by NYS OMH entitled “General Provisions for Involuntary Admission on Medical Certification” notes that the person may be kept for up to 60 days, provided there is no request for a court hearing.

DCS Role: The DCS is one of several individuals who are authorized to act as an applicant to initiate the 2 PC process.

MHL §9.37 – Application for Admission on Certificate of a Director of Community Services or Designee

- Directors of Community Services “or an examining physician duly designated by him or her” are authorized under §9.37 to apply for hospitalization of a person who “has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others.” This standard is the same as previously reviewed under §9.45 and §9.39. Please note that, unlike DCS designees under §9.45, the designee under this section MUST be a physician. An exception to this requirement is made for counties with a population of less than 200,000 where a DCS who is a licensed psychologist or licensed clinical social worker is allowed to initiate the §9.37 application for admission (providing a reasonable attempt has been made to find a physician and there is no 9.39 hospital within 30 miles of the patient).

This section of the law is commonly used in transferring individuals from one hospital emergency room (where there are no inpatient psychiatric beds or where the existing beds are full) to another hospital.

Transportation: Although the law allows for DCS designees to actually to “take into custody” and transport individuals, law enforcement and ambulance services are also specified in the law and are usually used.

Documentation: Upon personally examining the person, the DCS or designee fills out the brief “Application for Admission” form documenting the need for hospitalization (Form OMH 475). In addition, a Certificate of Examination (Form 475A for physicians; Form 475B for non-physicians) must be completed. Upon arrival at the hospital, a physician must confirm prior to admission that hospitalization is needed (and signs Form 475). Additionally, an
evaluation by another physician is required in order to retain the person in the hospital for more than 72 hours.

- **Cost:** §9.37 (e) states that “Reasonable expenses incurred by the director of community mental hygiene services or his designee for the examination and temporary care of the patient and his transportation to and from the hospital shall be a charge upon the county from which the patient was admitted and shall be paid from any funds available for such purposes.” However, generally the costs of transportation and admission are charged to the patient and/or their insurance carrier.

- **Outcome:** As mentioned above, upon arrival at a hospital, a physician needs to confirm that admission is warranted. Therefore, if that is not done (because the evaluating physician does not agree with the initial determination by the DCS designee), the person is discharged from the emergency room. While the statute does not specify the length of time that someone may be kept on a §9.37 admission status, the first page of the forms promulgated by NYS OMH (Form OMH 475) entitled “General Provisions for Involuntary Admission on Certificate of a DCS or Designee” details that the person may be kept for up to 60 days, provided there is no request for a court hearing. Thus, if the confirming physician agrees that admission is needed, the person may be kept up to 60 days on the §9.37 status.

- **DCS Role:** As mentioned above, in certain situations (counties whose population is less than 200,000 without a §9.39 hospital within 30 miles) a DCS who is a licensed psychologist or LCSW, may initiate the Application for Admission on Certificate of a Director of Community Services or Designee after an unsuccessful attempt to find a physician. Also, the DCS is the one who appoints DCS designees pursuant to §9.37. There is some variation between counties in the DCS designee appointment process under this section of MHL. Some counties appoint emergency room physicians to facilitate transfers for inpatient admissions. Other counties restrict §9.37 appointees to psychiatrists working in the public sector.

**MHL § 9.60 – Assisted Outpatient Treatment**

- §9.60 provides a method of obtaining a court order to require a person to comply with a specific treatment plan. The procedure to obtain such an order is quite detailed and the summary presented here is intended as an overview of the essential elements and should not be viewed as a standalone ‘how to’ manual. *Readers are strongly encouraged to read §9.60.*
consult with both your county AOT staff and your county attorney, as well as read the sections of the NYS OMH website referenced below.

Assisted Outpatient Treatment (AOT, or Kendra’s Law) is intended to address dangerousness that occurs when some adults with serious mental illness do not follow recommended treatment. The New York legislature passed the law in 1999 following Kendra Webdale’s death after she was pushed into the path of an oncoming subway by a seriously mentally ill man who was said to be chronically noncompliant with outpatient treatment. AOT is court-ordered outpatient treatment.

It is an LGU responsibility to operate, direct, and supervise an AOT program. The director of a hospital licensed or operated by NYS OMH may also operate an AOT program.

To be eligible for AOT, an individual must be:
- 18 or older, and
- mentally ill, and
- unlikely to survive safely in the community without supervision, and
- have a history of lack of compliance with treatment that has resulted in:
  - 2 psychiatric inpatient admissions in the past 36 months OR
  - At least one act of serious violence toward self or others, or threats of, or attempts at, serious physical harm to self or others within the past 48 months, and
- be unlikely to voluntarily participate in treatment, and
- based on history and current behavior, be in need of Assisted Outpatient Treatment in order to prevent relapse or deterioration that would likely result in serious harm to the individual or others, and
- be likely to benefit from AOT.

The essential element for eligibility is the lack of compliance with treatment that results in some level of dangerousness. Individuals might have repeated hospitalizations (and/or a history of serious violence towards self or others), but if the hospitalizations (or acts of violence) did not occur in the context of noncompliance, the individual would not be eligible for AOT.

The process of bringing petitions for AOT can be started by a variety of individuals including: an adult roommate of the person, the parent, spouse, adult child, or adult sibling, the director of a hospital where the person is hospitalized, the psychiatrist who is either treating or supervising the treatment, a psychologist or social worker who is treating the person, the director of community services, director of social services, and/or a parole or probation officer assigned to supervise the person.
After an examination by a psychiatrist (that confirms the individual is eligible for AOT), a petition is filed with the court. Before AOT can be ordered the court must be presented with a treatment plan (developed in collaboration with any outpatient providers that are involved with the client, the client when possible, and anybody else the client requests). All treatment plans must include either case management services or assertive community treatment (ACT). Other treatment categories that may be included are: medication, periodic blood tests or urinalysis to determine compliance with medication, individual or group therapy, day or partial programming, educational and vocational activities, alcohol and substance abuse treatment (including periodic tests for alcohol or illegal drugs), supervision of living arrangements, and other indicated services.

Initial AOT orders are for up to six months; subsequent renewals can be for up to one year.

Medication non-compliance is a major issue for many AOT clients. Please note that while the court order may direct the person to self-administer psychotropic medication or accept the administration of medication (i.e., depot injections), there is no provision in §9.60 to actually force an individual to take medication.

When an individual, in the clinical judgment of a physician, is not compliant with a court ordered treatment plan, attempts have been made to elicit compliance, and there is evidence that the person may need to be psychologically hospitalized, a "§9.60 pick-up order" may be issued at the request of the physician. Per the statute, the physician requests the DCS or any physician designated pursuant to §9.37, to direct the removal of the person to a hospital for evaluation. Individuals are then brought to a §9.39 hospital by law enforcement. Under these circumstances, individuals may be retained for up to 72 hours to determine if inpatient hospitalization is warranted.

Although not specified in §9.60, various counties use “voluntary agreements” with some individuals prior to initiating the more formal AOT proceedings. If individuals adhere to the recommended treatment plan, AOT proceedings can be avoided. Other counties use these voluntary agreements to help transition individuals off of formal court orders.

To determine eligibility, AOT programs must obtain and review an individual’s treatment record. Up until recently, AOT programs were allowed to obtain records pursuant to MHL §33.13 (c) (12).

The procedures for obtaining an AOT order were affected by a recent (May, 2011) decision of the NYS Court of Appeals in a case entitled In the Matter of Miguel M. v. Charles Barron. The decision of the court holds that "the Privacy Rule adopted by the federal government pursuant to the Health Insurance Portability and Accountability Act (HIPAA) prohibits the
disclosure of a patient’s medical records to a State agency that requests them for use in a proceeding to compel the patient to accept mental health treatment, where the patient has neither authorized the disclosure nor received notice of the agency’s request for the records."

Prior to this decision most AOT programs took the position that MHL §33.13 (c) (12) allowed for the disclosure of confidential records to a director of community services or his designee in the exercise of his or her statutory functions, powers and duties pursuant to section 9.60. HIPAA on the other hand provides that such records may not be disclosed without authorization or court order unless a HIPAA exception applies.

Prior to Miguel, most DCSs believed that HIPAA did not preempt the DCS’s authority under §33.13. The Court of Appeals has now held that it does. Therefore in order for a DCS or an AOT coordinator to now obtain hospital records in order to prove that there was a prior hospitalization either (1) the AOT subject has to consent to the release of records, (2) a court must order the release, (3) the records can be released under a HIPAA exception or (4) the records can be subpoenaed in the context of a court proceeding.

Miguel does hold that neither the HIPAA exception for treatment or for public health apply. There is also a HIPAA exception for obtaining Protected Health Information (PHI) without patient authorization for “health oversight activities authorized by law”. “Health oversight activities authorized by law” include: “audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; ...” Some have argued that this exception may be relevant and available.

Generally however continued implementation of the AOT program in most LGUs will involve a closer coordination with local counsel’s (county attorney or corporation counsel) offices and may require that a court proceeding be initiated at an earlier time in the AOT investigation so that appropriate records may either be subpoenaed or obtained by court order.

No summary of AOT would be complete without at least briefly mentioning that there is significant controversy about court-mandated outpatient treatment. Proponents cite the research demonstrating positive outcomes; opponents argue that having a better funded, more coordinated and accountable service system would be a more effective and appropriate way to address concerns. The law has been renewed two times, but is still not permanent. The current version is set to expire June 30, 2015.

For additional information about AOT, readers are referred to the NYS OMH website section about AOT. It contains background information, details about program administration, as well as a helpful frequently asked questions (FAQs) section.
Transportation: As mentioned above, individuals who are not compliant with court-ordered treatment and who are judged to possibly need hospitalization may be transported (via law enforcement and ambulance) to the emergency room of the hospital operating an AOT program or any other hospital authorized by the DCS.

Involuntary transport can also be initiated when an individual does not consent to the examination that is necessary to file the petition. A court order may be obtained that directs law enforcement to transport the person to a hospital emergency room. The person can be detained for up to 24 hours while arrangements are made for the examination to be completed. Of course, if the individual meets the criteria for hospitalization (pursuant to §9.39), hospitalization would ensue.

Documentation: Significant documentation is required to file an AOT petition. NYS OMH provides form templates that may be used. There are specific required time-lines for submitting documentation (e.g., an AOT petition must be submitted to the court within 10 days of a physician’s evaluation recommending AOT).

Pursuant to §9.60(n), an “Application for Hospital Examination after Failure to Comply with an order for Assisted Outpatient Treatment” [(Form OMH 485 (06/01)] must be completed prior to an involuntary transport of an individual who is not compliant with an AOT order (and thought to be in need of hospitalization).

Cost: Counties incur significant costs in operating an AOT program. Each county must have an AOT Coordinator and Attorneys (usually within County Law Departments) are needed to process the petitions and for court appearances. An examining physician is also expected to testify at AOT proceedings.

In 1999 when the AOT program became law, NYS OMH allocated infrastructure money to each county to offset the cost of operating the program. There are varying experiences across counties as to the extent the infrastructure money covered actual operating costs. In addition, it is important to note that recent (July 2011) state aid letters reduced the overall LGU infrastructure money available. Depending on individual county allocation methodology, the infrastructure money available for AOT may have been impacted.

According to §9.60 (e) (4), NYS OMH may provide a physician (“at no cost to the county”) to evaluate subjects of AOT petitions in counties where the population is less than 75,000.
- **Outcome**: The complete results of an [evaluation of AOT](#) (required by the statute) which was completed in 2009 are presented on the OMH website.

- **DCS Role**: Per §9.60, the DCS “shall operate, direct and supervise an assisted outpatient treatment program.” This requires myriad activities ranging from accepting referrals, determining eligibility, completing examinations, preparing and filing petitions, and monitoring compliance with court orders. The DCS is also responsible for appointing the examining physician that completes the treatment plan submitted to the court.

**NYS CORRECTION LAW**

NYS Correction Law (CL) governs many aspects of the functioning of local jails and correctional facilities. In particular, where and how incarcerated individuals in need of psychiatric hospitalization are referred for treatment is outlined in Corrections Law.

It is highly recommended that you obtain a copy of the [Mental Health Resource Handbook for Human Service Personnel Serving the Local Correctional Population](#) written by NYS OMH personnel in collaboration with the NYS Commission of Correction (revised 2001). It provides a very helpful overview of various issues that arise with individuals with mental illness in the criminal justice system, as well as step-by-step instructions for many specific procedures (e.g., the inpatient admission process for those that are incarcerated). It is available for download. However, please note that the forms (chapter 7) contained in the on-line version are outdated (as of this writing, February, 2012). Hard copies of the Handbook (with up-to-date forms) may be obtained from Maryann McNamara in the Division of Forensic Services ([Maryann.McNamara@omh.ny.gov](mailto:Maryann.McNamara@omh.ny.gov)).

**Hospital Admissions of Individuals Incarcerated in Local Jails (CL§508; CL §402)**

Research has shown, and our experience has confirmed, that a significant proportion of individuals detained in County jails suffer from mental illness. Although jails have the ability to prescribe and administer psychiatric medication and to a varying extent offer other supports, there are times that individuals need to be transferred to a psychiatric facility for further evaluation and treatment. NYS Correction Law (CL) governs how individuals who are incarcerated in local jails get psychiatrically hospitalized. CL §508 concerns unsentenced inmates; CL §402 relates to sentenced individuals.
**CL §508 – Removal of Sick Prisoners from Jail**

- Upon the determination by a jail physician that an inmate needs to be psychiatrically hospitalized, arrangements are made by jail staff to transport the individual to either a Forensic Unit or a general hospital containing a “psychiatric prison ward” for evaluation for admission. Admissions occur pursuant to §9.27, §9.37, or §9.39.

Most upstate counties use either the Northeast Central Regional Forensic Unit in Marcy or the Rochester Regional Forensic Unit to hospitalize inmates pursuant to CL §508. By definition, Forensic Units are secure facilities where hospitalized individuals are in custody (the Sheriff’s Department where the unit is located provides staff to the unit). Some counties use State Civil Psychiatric Centers (i.e., non-forensic units) or prison wards of local general hospitals.

Two other options are available for unsentenced inmates needing psychiatric hospitalization. If the Forensic Units and the local hospital prison ward (where they exist) are full, the local Sheriff’s Department, in consultation with local providers, may opt to hospitalize the individual in a local §9.39 hospital unit. §9.39 units not accustomed to this will, understandably, be resistant. Since the individual remains in custody (per CL §508), a Sheriff’s Deputy must be on the unit and most hospital personnel find this disruptive to the therapeutic milieu.

The other option that falls outside of CL §508 is to have the person released from custody for the purposes of psychiatric hospitalization. The advantage to this approach is that it is likely the individual will be hospitalized closer to home. In addition, by decreasing referrals to Forensic Units, it preserves the limited space available for when it is absolutely necessary to use them (i.e., those accused of violent felonies). Finally, significant cost savings are realized by avoiding a Forensic Unit admission (discussed below). Some counties have instituted a process whereby unsentenced non-felony offenders needing hospitalization are hospitalized at community §9.39 facilities. Appendix 4 contains a summary flow chart outlining how this is accomplished in one county.

While jail personnel are responsible for monitoring the condition of incarcerated individuals, county mental health staff (or contracted providers) may play a role in determining who needs to be hospitalized pursuant to CL §508.

- **Transportation**: Local jail personnel are responsible for arranging and providing transportation to a Forensic Unit. Remember that individuals hospitalized pursuant to CL §508 remain in custody. Therefore, when the inpatient treatment is completed the Sheriff’s Department will transport the person back to jail.
o **Documentation:** A completed §9.37 or §9.27 is needed to initiate a transfer to a Forensic Unit. Other documentation (prepared by jail personnel) includes the detainee’s medical record, health and custodial transfer information, and a copy of the securing order.

o **Cost:** Counties (LGUs) are required to pay one-half of the per diem cost. The 2012 per diem costs are as follows:
  - Mid Hudson (Marcy): $805.61
  - Rochester Regional Forensic Unit: $944.46

There is also a charge-back to the Sheriff’s Department of origin to the Sheriff’s Department staffing the Forensic Unit.

o **Outcome:** In most circumstances, those admitted to a Forensic Unit via CL§508 return to jail after they no longer need inpatient psychiatric treatment.

o **DCS Role:** The DCS or a DCS designee will be involved if the transfer is taking place via §9.37 (as “the applicant”). The DCS may also be asked to be “the petitioner” if the transfer is taking place via §9.27.

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**CL §402- Commitment of Mentally Ill Inmates**

- CL 402 is the section of law that guides the process of psychiatric hospitalization of sentenced inmates in local jails (or State prisons). Outside of New York City, the Northeast Central Regional Forensic Unit (Marcy) accepts CL §402 patients. In NYC, Bellevue and Kings County Hospitals accept admissions pursuant to CL §402.

Four types of admissions (Signed Commitment, Emergency Commitment, Forthwith Commitment, and for NYC only – Observation and Examination) are possible via §402 (details of which are delineated in the Mental Health Resource Handbook, referenced above, and are beyond the scope of the current discussion). Suffice it to say that mental health personnel must be involved in evaluating an inmate and making the determination that the person has a mental illness for which inpatient treatment is necessary.

o **Transportation:** Consistent with what occurs with unsentenced individuals hospitalized under §508, local jail personnel (in most cases staff from the County Sheriff’s Office) is responsible for transporting individuals to the Forensic Unit where they will be hospitalized. The transporting agency is responsible for returning the individual back to the facility where they were upon completion of inpatient treatment.
o **Documentation:** Two physicians need to examine the individual and document the rationale for hospitalization (on Form 402.4). Jail personnel are responsible for sending supporting documentation and specific forms.

o **Cost:** Other than transportation costs incurred by the sending County Sheriff’s Department, the State is responsible for all other costs. The exceptions to this are those from the NYC area that are hospitalized at Bellevue or Kings County Hospitals. In those cases, the City is responsible for the cost of the inpatient service.

o **Outcome:** Sentenced inmates are returned to the jail upon completion of inpatient treatment. If the person’s sentence expires when they are on the Forensic Unit and continued inpatient treatment is necessary, presumably arrangements would be made to have them transferred to a non-forensic (i.e., civil) unit.

o **DCS Role:** There is no direct role for the DCS in arranging hospitalization for sentenced inmates in local correctional facilities.

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**NYS CRIMINAL PROCEDURE LAW**

Criminal Procedure Law (CPL) governs all criminal proceedings and actions in courts. Of particular relevance to this Manual are issues that arise when those with mental illness are involved in criminal courts. The question of competency (or fitness to proceed; CPL §730) is the most common concern that is raised. Other issues include Pre-Sentence Mental Health Examinations (CPL §390.30), Examination of A Defendant Upon Application of Prosecutor (CPL §250.10), and procedural issues regarding pleas of Not Responsible by Reason of Mental Disease or Defect (CPL §330.20).

**CPL §730 – Mental Disease or Defect Excluding Fitness to Proceed**

- Referred to as Competency, Capacity and/or Fitness to Proceed exams, “730” evaluations are conducted to determine whether a criminal defendant, as a result of mental illness or ‘defect,’ lacks the capacity to understand the proceedings against them and/or assist in their own defense. 730 evaluations assess the person’s overall mental status, their understanding of the charges against them, whether they are able to consult with their attorney in a meaningful and collaborative way, and whether they have a basic understanding of courtroom proceedings (e.g., the differences between the judge, prosecutor and defense attorney). A recent review article provides additional information about the evaluation process.
The question of competency can be raised at any time from arraignment until sentencing. It is usually raised by the defense attorney, although the prosecutor and/or judge could introduce the issue as well. The process, however, begins with an order from the court.

Please note that competency evaluations are separate from determinations about criminal responsibility (discussed below in CPL§ 330.20). Decisions about competency are based on the person’s condition at the time of the evaluation and their ability to engage in the court process; it is not about the person’s mental status at the time of the alleged crime.

Whereas specific checklists may be employed as part of the evaluation process (as detailed in Appendix 5), the core of the evaluation is an interview conducted by two “qualified psychiatric examiners.” Qualified examiners are defined as board-certified or board eligible psychiatrists or licensed psychologists (examiners can be two psychiatrists, two psychologists, or one of each). Many jurisdictions opt to conduct 730 evaluations with both examiners present, although they may be completed independently. Although not required, it is often helpful to have the defense attorney present to be able to more thoroughly evaluate the ability of the client to collaborate with his/her attorney. In addition, the court may authorize a psychiatrist or psychologist retained by the defendant to be present at the evaluation.

To begin the competency evaluation, the court issues “an order of examination” which, in most cases, is directed to you (the DCS). The DCS then appoints two qualified examiners to complete the examination. If an individual is incarcerated at the time, the examination takes place in jail. If the person is out-of-custody, the exam takes place out-of-custody. However, in either of these cases (incarcerated or out-of-custody) if it is determined that it is necessary to complete the examination in a hospital, the person can be admitted to a Forensic Unit for that purpose (after informing the court and the court orders that). Hospitalizations for the purpose of assessing competency may not extend beyond 30 days, unless authorized by the court. Please note that it is up to the DCS to determine whether hospitalization is necessary. Of course, this determination is based on the examiners you designate and does not mean that you need to conduct an independent evaluation to determine the necessity of hospitalization.

The question of competency may also arise with regard to a juvenile against whom a juvenile delinquency petition has been filed (Family Court Act, §301.2 (13)). If the family court judge believes that reason exists, the child can be ordered to undergo a capacity examination to determine whether the child “lacks capacity to understand the charges or to assist in his own defense.” Additional details specific to juveniles undergoing capacity examinations are found in Family Court Act, §322.2.
Transportation: The Sheriff’s Department is generally responsible for transportation, if required, under CPL §730. As detailed above, if it is determined that an individual needs to be confined in a hospital to complete the 730 exam, the court must order that. In such cases transportation from the jail to the hospital (Forensic Unit) is provided by the Sheriff’s Department. Likewise, the Sheriff’s Department will transport individuals who are found not competent of a felony charge (detailed below under Outcome) to a Forensic Unit (upon the direction of the NYS OMH Division of Forensic Services) or to a Developmental Center (upon the designation from OPWDD). Finally, the Sheriff’s Department also provides transportation to the hospital or a Developmental Center for those found not competent of a misdemeanor charge.

Documentation: Each examiner is required to fill out the form entitled “Examination Report” (C.P.L. Article 730)” (FORM AHR 704) that is submitted to the court. For those individuals that are judged to be competent, no clinical information is submitted. The examiner simply signs the form (after filling out some basic information about who ordered the exam and where it took place) indicating that the person is competent to proceed.

When a person is judged to lack capacity to understand the proceedings against him/her or to assist in their own defense, documentation is required to support that decision. Required elements of documentation include: 1) History and Clinical Summary, 2) Diagnosis, 3) Prognosis, and 4) Reasons for the Opinion. The extent of documentation varies as a function of local practice and the nature of the charges. Nevertheless, it is important to note that 730 evaluations are meant to only address the issue of competency.

Cost: The County is responsible for the cost of conducting competency exams. (It should be noted that the specific fee structure outlined in CPL §730.20 (7) is below current standards.)

The County is charged for 50% of the per diem costs for individuals hospitalized pursuant to §730; those hospitalized in order to complete the competency exam as well as those hospitalized on a temporary order of commitment (to be restored to competency). The specific (full) per diem charges (as of 2012) are as follows:

- Kirby Forensic Psychiatric Center: $805.61
- Mid Hudson (Marcy): $805.61
- Rochester Regional Forensic Unit: $944.46
- OPWDD Developmental Centers: $509.94 (2011 rate)
After identifying a three year trend in the increase of forensic bed utilization days for individuals determined to be incompetent to stand trial, Orange County implemented a Lean Six Sigma Project. Results demonstrate an estimated decrease of over $180,000 annually. (Appendix 5 contains a comprehensive PowerPoint about this project).

The county is **not** responsible for the cost of those hospitalized or placed in the OPWDD system on a final order of commitment (i.e., those found not competent on a non-felony charge).

Since Forensic Unit costs are directly related to the length of stay, DCSs should be aware of certain provisions in the law that limit length of stays. As detailed below, CPL §730.50 mandates that an individual cannot be held under 730 longer than two-thirds of the maximum possible sentence. In addition, individuals cannot be held longer than is necessary to determine whether they can be restored to competency (see discussion of Jackson v. Indiana on page 32). By monitoring the length of stay of those committed to a Forensic Unit to be restored to competency, the DCS should be aware of individuals who may be approaching two-thirds of their maximum sentence and those for whom the question of whether they are restorable should be pursued.

**Outcome:** Please note that if the two examiners are not unanimous in their opinion, then the DCS needs to appoint a third examiner. It is important to remember that the results from the examiners are not the actual outcome of the 730 evaluation process. They are merely a report to the court which makes the final determination either with or without a hearing.

If the court finds the person "fit to proceed" then the case will proceed as usual. Should the defendant’s mental status deteriorate as the case progresses, the issue of competency could be raised again and the judge has the option of ordering another 730 examination.

If the court determines that the person is not competent, then the outcome depends on whether the alleged crime is a misdemeanor or a felony. If it is a misdemeanor, then the charges are dismissed and the person is ordered to the Custody of the Commissioner (of NYS OMH or, on occasion, the Commissioner of NYS OPWDD if it is determined the primary disability is developmental rather than psychiatric) via the court issuing a final order of observation (§730.40). This means that, upon designation by the NYS OMH Division of Forensic Services, the person will be transferred to a state psychiatric facility (non-forensic unit) for observation and treatment.
Although CPL §730 states that the order shall commit the person for a period not to exceed 90 days, following a court case (Ritter v. Surles, 1988), NYS OMH concluded that individuals must be evaluated within 72 hours of admission to determine whether they meet the criteria for continued hospitalization under NYS Mental Hygiene Law.

OPWDD procedures are somewhat different. Individuals found not competent to proceed on a misdemeanor charge who are designated to a DDSO facility are initially evaluated for eligibility for services. If they are not eligible (i.e., there is no developmental disability diagnosis), they are released. If the person is eligible for services and determined to be dangerous, a two-physician certificate is completed. Please note that OPWDD requires involuntary or “2 PC” paperwork that is different than the forms used within the mental health system (Forms OMR 43 & OMR 43A pursuant to MHL §15.27). OPWDD protocol is to ask the County to provide a physician to complete one of the certificates. Within the OPWDD system, if a person meets the criteria for admission and is willing to sign the voluntary admission paperwork (and is judged to understand the content of those documents), they are admitted on a voluntary status. This enables their placement in any residential setting within the system. However, individuals admitted on an involuntary status must be placed in a Developmental Center.

When an individual is found to be not competent to proceed on a felony charge, in most circumstances the court will issue a temporary order of observation (via §730.40) and the person will be brought to a forensic unit to be restored to competency. (It should be noted, however, that with the consent of the DA, final orders can be issued in misdemeanor cases.) Pre-indictment requires an initial commitment of up to 90 days; post-indictment on a felony charge requires an initial commitment of up to one year (CPL §730.50 (1)). Subsequent petitions for further retention may be requested so long as the total time the person is retained doesn’t exceed two-thirds of the maximum possible sentence they could receive if convicted of the crime for which he or she was originally charged. Upon reaching two-thirds of the maximum possible sentence, the person is released from custody, and hospitalized pursuant to MHL statutes, if applicable. CPL §730.70 allows an additional 30 days after the expiration of a final or temporary order of observation to determine whether the individual requires continued care and treatment in an institution.

Please note that Part 540 (of Chapter XIII of Title 14) of the Codes, Rules and Regulations of NYS details additional operational aspects of individuals committed to the custody of the
commissioner pursuant to CPL §730. Although Part 540 does not apply to OPWDD, they follow the same process.

If it is determined that the person will be unlikely to be restored to competency, the court can hold a “Jackson Hearing.” In Jackson v. Indiana (U.S. Supreme Court, 1972) it was determined that defendants “cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that (s)he will attain capacity in the foreseeable future.” When a person is determined ‘unlikely to be restored to capacity,’ they are discharged from the custody of the Commissioner (i.e., released from a forensic unit) and hospitalized pursuant to MHL statutes, if applicable.

- **DCS Role:** As noted above, the DCS is responsible for appointing qualified examiners to conduct 730 evaluations. Provided the DCS meets the definition of a qualified examiner, the DCS is allowed to be one of the two evaluators.

As alluded to previously, the DCS may play a role from a cost containment perspective. That is, the DCS should consider monitoring the length of stay for those individuals committed to a forensic unit to be restored to competency (via a Temporary Order of Observation pursuant to CPL §730). Individuals who are maintained under this status for an extended period of time, may need to be evaluated to determine whether they are “restorable.” Although the DCS has no official standing in this matter, given that the LGU is charged for half of the cost of these hospitalizations, the DCS may wish to raise the issue to the Forensic Unit staff, the Court, and/or the individual’s attorney. This issue is relevant to those committed to both the Commissioner of NYS OMH and the Commissioner of NYS OPWDD pursuant to CPL §730.

*CPL §390.30 – Scope of Pre-sentence Investigation and Report*

- Mental health evaluations often take place as part of a pre-sentence investigation to inform the court about any mental health issues that may be relevant to sentencing or other dispositions. There are three ways this can take place pursuant to CPL §390.30. The court may order it directly, the defense counsel or DA may request it (as long as the court consents), and/or it can take place as part of the probation department’s pre-sentence investigation (in which case the probation department requests it directly).

Usually these exams take place on an outpatient basis (via a county mental health clinic or a forensic court clinic in those localities that have such a service). There is a provision in the law, however, that allows for the
court to order the individual to an inpatient facility for up to 30 days to complete the evaluation.

Unlike CPL §730 where there are only two types of professionals currently qualified to conduct competency evaluations (psychologists and psychiatrists), §390.30 contains no such restrictions.

- **Transportation**: Although not directly addressed in §390.30, transportation to the hospital, when an inpatient examination is ordered, would likely take place by the local sheriff’s department (when transferred from jail) or by local law enforcement (if the person is not in custody when an inpatient exam is ordered). Transportation to outpatient exams is the responsibility of the defendant.

- **Documentation**: There is no specified format for the examination report submitted to the court or probation.

- **Cost**: While the county is responsible for the cost of the examination, there is some variability in the local arrangements to cover those costs. Some county-run clinics may absorb the costs associated with the evaluation into their ongoing operations. Some local arrangements might include the expectation that contracted providers conduct these evaluations (as either part of their contract or on a fee-for-service arrangement). Finally, there may be some counties that have a payback procedure where the LGU (or contracted county provider) is reimbursed directly by the courts for this service. The county is also responsible the cost of inpatient admissions ordered by the court pursuant to §390.30.

- **Outcome**: The outcome is that the court and/or probation will have a report upon which to base disposition decisions.

- **DCS Role**: There is no direct role for the DCS specified in §390.30, although it would be important for the DCS to ensure that clinicians with sufficient skills are available in the system to conduct these sorts of evaluations.

**CPL §250.10 – Examination of Defendant Upon Application of Prosecutor**

- CPL §250.10 notes that if a defendant plans to introduce psychiatric testimony relating to their defense, then both the district attorney and the court must be notified in advance. Two specific examples are noted:
  1. If a defendant intends to prove a lack of criminal responsibility by reason of mental disease or defect (commonly referred to as “not guilty by reason of insanity” or NGRI), or
2. If a defendant plans to introduce the defense of “extreme emotional disturbance” in defense of murder charges. In addition to these two instances, CPL §250.10 also states that there must be notice given for “evidence of mental disease or defect to be offered by the defendant in connection with any other defense” as well.

Upon receiving notice that the defense plans to introduce psychiatric testimony, the district attorney may apply to the court for an order directing the defendant to submit to an examination by a psychologist or psychiatrist designated by the DA.

- **Transportation**: This is not addressed in CPL §250.10. Presumably if a defendant is in custody, the examination will take place in jail. If the defendant is not in custody, the defendant would be responsible for arranging transportation to the examination. (Under CPL §250.10 the psychologist or psychiatrist specifies the time and place of the evaluation).

- **Documentation**: The psychologist or psychiatrist must provide a written report to the DA and defense counsel.

- **Cost**: Cost is not specifically addressed in CPL §250.10; presumably any costs incurred for the examination requested by the DA’s office would be the responsibility of that office.

- **Outcome**: The ultimate outcome of the case depends on many factors; the immediate outcome of the evaluation conducted pursuant to CPL §250.10 is a written report available to the pertinent parties.

- **DCS Role**: No specific role or authority is given to the DCS in CPL §250.10.

**CPL §330.20 – Procedure following Verdict or Plea of Not Responsible by Reason of Mental Disease or Defect**

- This section of law covers what happens after a determination that an individual is determined to be “not responsible by reason of mental disease or defect” (commonly referred to as “not guilty by reason of insanity” or “NGRI”). John Hinckley’s successful use of this defense (after his attempted assassination of President Reagan in 1981 to impress actress Jodie Foster) and Jeffrey Dahmer’s failed defense (of multiple murders in 1992) are among the incidents that account for this being a well-known aspect of forensic mental health by the general public. However, contrary to popular belief, this defense is seldom used, and is rarely successful.
Upon a verdict of not responsible by reason of mental defect or disease, the court must order an examination which is conducted by two psychiatric examiners (board certified or board-eligible psychiatrists or licensed psychologists) to determine whether the person has a mental illness, and if so, whether it is a “dangerous mental disorder.” CPL §330.20 also makes reference to determining whether the person is “mentally retarded.” The person is also required to be transported to a secure NYS OMH or OPWDD facility.

- **Transportation**: The Sheriff’s Department provides transportation.

- **Documentation**: “Form Y (Examination Report by Qualified Psychiatric Examiner”) is filled out by both psychiatric examiners that indicates whether the person has 1) a dangerous mental disorder, 2) a mental illness that is not dangerous, or 3) neither a dangerous mental disorder or mental illness. A full written report detailing the reasons for the conclusion stated on the form is also required.

- **Cost**: Unlike hospitalizations pursuant to CPL §730 or CL §508, the County is not responsible for commitments pursuant CPL §330.20 that result in admissions to a NYS OMH forensic unit, a NYS OMH civil psychiatric unit, OPWDD Developmental Center, or other residential services within the OPWDD system.

- **Outcome**: Following the verdict of not responsible by reason of mental defect or disease, the court will direct subsequent processes to take place within the NYS OMH or NYS OPWDD systems, as detailed below.

  Regardless of the system that the person is directed to, the person is evaluated to determine whether they suffer from a mental illness/developmental disability and, if so, whether it is a “dangerous mental disorder.”

In those cases where the court determines that a person has a “dangerous mental disorder” the court issues an “order of commitment” to a secure forensic facility. Within the OMH system these placements occur at the Kirby Forensic Psychiatric Center, Mid-Hudson Forensic Psychiatric, or the Rochester Regional Forensic Unit. Within the OPWDD system these placements occur at a “designated secure facility”; Sunmount, Valley Ridge, or the Finger Lakes DDSO. Initial orders of commitment are for six months, but can be renewed.

In cases where the person is determined to have a mental illness or developmental disability that is not dangerous, the individual would either be committed to a (non-forensic unit of a) state psychiatric...
center (pursuant to MHL §9.27, §9.37, or §9.39) or placed in the OPWDD system. Options within the OPWDD system include a commitment to a Developmental Center (pursuant to MHL §15.27) or an admission on a voluntary basis.

The other possibility is that the court finds (based on the psychiatric examiners’ reports) that the person does not suffer from a mental illness or developmental disability. In that case, the person is released to the community.

Regardless of initial findings and subsequent commitments, individuals may progress from a secure setting to a non-secure or civil placement, eventually resulting in a community-based placement. Placements in the community, however, are done with an “Order of Conditions” – requiring judicial monitoring of the person for at least five years. For a more detailed discussion of this and related issues for individuals within the OMH system, the reader is referred to Chapter 6 of the previously mentioned Mental Health Resource Handbook for Human Service Personnel Serving the Local Correctional Population. Also, please note that Part 541 (of Chapter XIII of Title 14) of the Codes, Rules and Regulations of NYS contain additional operational details regarding individuals committed to the custody of the commissioner pursuant to CPL §330.20.

- **DCS Role**: There is no defined role for the DCS in proceedings related to CPL §330.20. However, the DCS may become involved when individuals who are released to the community under an Order of Conditions. The court and District Attorney must be notified if a person is not compliant with the Order of Conditions.
SPECIAL ISSUES

JUVENILES¹

While technically a DCS does not have an official role with regard to the examination or transfer of a juvenile (usually a person under 16 years old) the local social services commissioner does and your aid or assistance may therefore be sought in such a situation so you should be aware of what the relevant statutes require.

A person under age 16 who commits an offense which would be considered a crime if committed by an adult is usually referred to Family Court rather than an adult court. (A juvenile who is accused of having committed some serious offenses may be treated as an adult in which case this would not apply). Generally however, if it is determined by the Family Court Judge, after a hearing, that the juvenile (referred to as the respondent) committed the offense he or she may be found by the Court to be a juvenile delinquent. Upon such a finding the court then is required to hold a dispositional hearing (a sentencing hearing) to determine what to do with the respondent. If there is a question about the respondent’s mental state (i.e., mental illness or mental retardation/intellectual disability) the relevant mental hygiene commissioner shall be afforded an opportunity to be heard at such hearing.

As mentioned previously under CPL §730, the question of competency may arise with regard to a juvenile against whom a juvenile delinquency petition has been filed (Family Court Act, §301.2 (13)). If the family court judge believes that reason exists, the child can be ordered to undergo a capacity examination to determine whether the child “lacks capacity to understand the charges or to assist in his own defense.” Additional details specific to juveniles undergoing capacity examinations are found in Family Court Act, §322.2.

§353.4 of the Family Court Act provides that if a Family Court Judge determines that a respondent, who has been found by the court to have committed a less serious offense, has a mental illness, mental retardation or developmental disability which is likely to result in serious harm to himself or others, the court may issue an order placing such respondent in the custody of the division for youth or a local commissioner of social services but also providing for the temporary transfer of the juvenile to the custody of either the commissioner of mental health or the commissioner of the office of people with developmental disabilities. The relevant commissioner shall then be responsible for arranging for the admission of the respondent to the appropriate departmental facility.

The definition of “Likelihood to result in serious harm” for this purpose is somewhat different than in an adult situation. For purpose of this section of law it means either “a substantial risk of physical harm to himself as manifested by threats or attempts at suicide or serious bodily harm or other conduct demonstrating he is dangerous to himself or a substantial risk of physical harm to

¹ Jed Wolkenbreit wrote this section.
other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious bodily harm”. Contrasted with the adult standards this is more a “suicidal or homicidal” standard than a “can’t take care of himself” standard and it must be supported by two examining physicians.

§251 of the Family Court Act provides for court ordered examinations by a physician, psychiatrist or psychologist appointed or designated for that purpose by the court. The Court may remand the respondent to a hospital or a qualified private institution approved for such purpose by the local social services department. Outside of NYC, if the court shall order a psychiatric examination of any such person, the court may direct the director of an institution in the department of mental hygiene serving the institutional district in which the court is located to cause such examination to be made.

In cases involving less serious “crimes”, if the juvenile is admitted to an OMH operated hospital, the director of the hospital may arrange to transfer the youth to a residential treatment facility for children and youth if care and treatment in such a facility would more appropriately meet the needs of the respondent. Juveniles transferred under this provision may be retained for up to a year and when appropriate should be transferred back to the custody of the division for youth or the local social services commissioner. At that time a further hearing should be held in Family Court to determine the further disposition of the matter.

If the offense committed is a more serious offense (certain designated felonies) the Family Court Judge may determine that a “restrictive placement” is needed. In such cases, if the court also determines that the respondent has a mental illness, mental retardation or developmental disability, and meets the likely to result in serious harm to himself or others standard, the court may order direct temporary transfer of the respondent, for a period of up to one year, to the custody of the commissioner of OMH or OPWDD. The relevant commissioner shall then arrange for the admission of the respondent to an appropriate facility under his or her jurisdiction within thirty days of such order. The director of the facility so designated by the commissioner must accept such respondent for admission. At any time prior to the expiration of the court ordered period, if the director of the facility determines that the child is no longer mentally ill or no longer in need of active treatment, the responsible office shall make application to the family court for an order transferring the child back to the division for youth. Within thirty days before the expiration of the court ordered period, there shall be a hearing to determine whether further treatment or further restrictive placement is appropriate.

MHL § 9.49 is the corresponding provision of the mental hygiene law governing the procedures to be followed with regard to any juvenile transferred to the temporary custody of a Mental Hygiene commissioner under the Family Court Act. Once the order for transfer has been issued the relevant mental hygiene commissioner must receive the youth into custody and arrange for admission to an appropriate office facility.
Upon admission the director of such facility must give the youth notice of his or her status and rights as required by MHL §9.07 and the mental hygiene legal service must contact such juvenile and explain and make available its services. Any juvenile placed pursuant to section this section is subject to all of the provisions of article nine of the MHL.

A Family Court judge also shall have the authority to order a transfer pursuant to MHL §9.43 for emergency admissions for immediate care, observation and treatment of a person who comes before the court.

CONFIDENTIALITY & PRIVACY

A full discussion about confidentiality and privacy is beyond the scope of this Manual. However, given the frequency with which questions arise in this area, brief mention of these topics is warranted, particularly as they pertain to the interface between the mental health and criminal justice systems.

It is important to note that many providers continue to cite the Health Insurance Portability and Accountability Act (HIPAA) as the main reason why they can’t release information to law enforcement, regardless of the circumstances. Please note, however, that there are law enforcement related exceptions to HIPAA that permits providers to release information to law enforcement under specific circumstances. Likewise, MHL §33.13(c)(9)(ii) permits disclosure to law enforcement under certain situations. Although both HIPAA and MHL permit disclosure, it does not appear that either compels disclosure to law enforcement under most circumstances (absent a subpoena or court order). Please note that the law enforcement related exceptions to HIPAA do not pertain to drug and alcohol treatment facilities. Absent client consent, a court-order must be obtained (pursuant to 42 CFR Part 2), in order for a drug and/or alcohol treatment facility to release client information.

Readers may wish to review OMH’s HIPAA Preemption Analysis. As stated in the introduction, it “is designed to examine the interplay between the HIPAA Privacy regulations (45 CFR Parts 160 and 164) and a variety of New York State statutes, regulations, and other precedent most commonly referred to when using and disclosing mental health treatment information.” The usual caveats are present; it is not intended as a substitute for legal advice and readers are encouraged to consult their own attorneys. It is, however, an excellent resource and well worth reading.

PROBLEM-SOLVING COURTS

Routine adjudication of individuals with mental illness, chemical dependency, and other specific challenges is often problematic. In response to this issue, many jurisdictions across the nation have developed problem-solving courts that address a wide variety of problems. Combining enrollment in specific treatment
programs with ongoing judicial monitoring is the hallmark of these courts. In New York, CPL §400.10 (4) allows judges to set conditions after conviction and before sentencing and is the legal authority under which many Drug and Mental Health Courts operate. Although the DCS has no statutory authority in these courts, the LGU’s support and/or involvement can be crucial to a court’s success.

The New York State Unified Court System maintains a website devoted to information about the New York’s Problem-Solving Courts. The Council of State Governments’ Justice Center provides more detailed information about Mental Health Courts and other criminal justice/mental health initiatives. In addition, the Center for Court Innovation (the research and development arm of the NYS Unified Court System) offers technical assistance in developing and/or evaluating problem-solving court initiatives.
Frequently Asked Questions

**DCS Designees**

- Who is allowed to be a DCS Designee?

As noted in the section regarding MHL §9.45 (on p. 11, under the “DCS role” section), the only definition in MHL is in §9.37 which refers to physicians. Thus, an individual acting as a DCS designee and applying for a psychiatric admission must be a physician (with the exception of certain rural counties, as detailed on p. 18 under the MHL §9.37 section).

The law also allows for DCS Designees to act pursuant to MHL §9.45 (to direct the removal of someone to a 9.39 hospital or CPEP). There are no criteria listed under §9.45 and thus, some counties have appointed non-physicians to act as DCS designees.

- What is the process of appointing DCS Designees?

There is no process outlined in MHL or in NYS Regulations for appointing DCS Designees, and thus, counties have some flexibility in developing and implementing their own processes. Appendix 3 provides examples of policies and procedures for appointing DCS designees.

- Once someone is appointed as a DCS Designee, how long is the ‘designee’ status good for?

Again, since the law and regulations are silent on this matter, it is up to individual counties to determine the procedure for maintaining their DCS Designee list.

**Emergencies / MHL §9.45**

- I’m a little confused by the 9.45 form. Some of the primary therapists in my clinic are LMHCs. But since they have MAs in psychology or counseling, they don’t appear on the list of individuals authorized to report to the designee someone who is in need hospitalization. What are they supposed to do in emergency situations where the LCSWs in my clinic could report directly to the designee?

NYS MHL has not kept up with the Education laws which recognize other education and experience. This creates the dilemma that you describe. Either the designee themselves need to see the client prior to initiating the 9.45, or hear from another authorized reporter about the situation.
• Emergency Medical Service (EMS) personnel in my community sometimes call the police to ask them to initiate a MHL §9.41 – when someone refuses to go to the hospital whom they believe needs emergency medical attention. If the police refuse to do that (as they sometimes do), can I (or my designees) initiate a 9.45?

As noted on page 9, there are two elements needed to initiate a 9.45. Individuals must have a mental illness and there must be some evidence of dangerousness to the point that hospitalization may be warranted. Many medical emergencies meet the dangerousness standard, but without evidence of mental illness, initiating a 9.45 would be inappropriate.

CPL §730 Issues

• What can I do when I receive an order for a competency exam but it appears (based on the accompanying information) that the Court may be more interested in a general mental health evaluation (pursuant to CPL §390.30)?

Under those circumstances, calling the court and talking either directly to the judge or the clerk is recommended. It is helpful to explain that the results from the competency exam will only address the issue of competency and not any disposition recommendations. This might result in the court deciding to retract that order and request an exam (via CPL §390.30). Should that occur, you need only to arrange for one evaluator, as opposed to the two that you need for a 730 exam.

• I received a CPL §730 evaluation order from the court on an inmate that was recently transferred (via CL §508 to a Forensic Unit). What do I do?

You have a few options. First, you can have the examiners you appoint to do the examination go to the forensic unit to conduct the evaluation. If that is not feasible (due to distance or other factors), you can talk to the forensic unit staff and/or the DCS where the forensic unit is located and see whether arrangements can be made to have others complete the exam. Finally, after consultation with the court, you might opt to wait until the person returns to jail to conduct the evaluation.

Fiscal Concerns

• The cost of inpatient forensic unit admissions are breaking my budget. What can I do to decrease the costs associated with CL §508 and CPL §730 admissions?
Similar to Orange County’s project (Appendix 5), conducting a thorough analysis of all the contributing factors to your situation would be helpful. Factors to consider include, but are not necessarily limited to:

1. Assessing the extent and quality of current outreach programs (e.g., ACT and mobile crisis) you have in your system (to intervene prior to law enforcement involvement is necessary and thus, prevent arrest and incarceration),
2. Examining how police procedures (and training or lack thereof) may contribute to the rate of individuals with mental illness who are incarcerated,
3. Evaluating the current jail procedures regarding the assessment and treatment of mental illness,
4. Tracking the specific court process with 730 cases (to determine if there are lengthy delays in individuals returning to court after the forensic unit has determined they have been "restored,"
5. Determining whether there are alternatives to using the forensic unit for all those needing inpatient admissions (see Appendix 4),
6. Instituting a mechanism to monitor length of stays for individuals admitted to a forensic unit pursuant to CL §508 and those committed to either a forensic unit or Developmental Center via CPL §730, and
7. Using the **Sequential Intercept Model** to determine where there are gaps in your system that need to be addressed.

**Other Concerns**

- *I have a challenging situation that is not addressed anywhere in this manual. Where can I get help?*

Depending on the nature and type of problem, options that exist include:

1. Consulting with colleagues (via the CLMHD listserv or other means),
2. Consulting with your County Legal Department,
3. Consulting with the CLMHD Legal Counsel (Jed Wolkenbreit; jbw@clmhd.org) , and/or
4. Consulting with NYS OMH and/or NYS OPWDD Counsel’s Office and/or the NYS OMH Division of Forensic Services or the OPWDD Bureau of Forensic Services.
Appendix 1

Examples of Law Enforcement Transport Forms

Pursuant to NYS MHL §9.41

From:

Monroe County

Oneida County

Ulster County
Monroe County Mental Hygiene Form

1. Incident Type
2. Time of Occurrence
3. When Reported
4. CR# 

5. Dispatched to (House #, Street, C/T/V) 
6. Location of Incident (House #, Street, C/T/V) 


| Name (Last, Middle, First) | Sex | Race | D.O.B. | Address (House #, Street, C/T/V) | Day | Eve.
|---------------------------|-----|------|-------|---------------------------------|-----|------
|                           |     |      |       |                                 |     |      
|                           |     |      |       |                                 |     |      

8. Where Hospitalized
9. Physical Injuries
10. Tech Work
11. Should police be contacted before patient release? ☐ Yes ☐ No

If yes, whom should hospital contact? Officer Name Car# Phone

12. Does patient have history of assault/violent behavior? ☐ Yes ☐ No ☐ Unknown

13. Did patient require physical restraint? ☐ Yes ☐ No

14. What behaviors or actions indicate the person might be a danger to self or others: (check all that apply)

☐ Placed self in dangerous situation
☐ Physical threats
☐ Unable to care for self
☐ Attempted to hurt/kill self/others
☐ Verbal threats
☐ Presence of weapons (specify)
☐ Other (specify)

15. Narrative: Describe additional details of the incident not listed above. Use appropriate code to expand on above information.

16. Follow-up by: Date Due: 17. Police Agency 18. Section/Zone

19. Reporting Officer ID/IBM# Beat# Car# 20. Assisting Unit(s) 21. Approval
TO: ☐ ST Elizabeth Medical Center ☐ Faxton St. Luke’s Healthcare ☐ Rome Memorial

Law Enforcement Request for Examination

TO:
ST Elizabeth Medical Center
Faxton St. Luke’s Healthcare
Rome Memorial

TYPE: ☐ 9.41 ☐ 9.45 ☐ 9.55 ☐ 22.09 ☐ Other (specify)

Police Agency: Incident # Officer’s Name:

Date: Time of Complaint: AM PM Time of Transport: AM PM

Ambulance Co: Location of Incident:

Last Name ____________________________ First Name ____________________________ MI __________
Address (Street) ____________________________ City ____________________________ State __________
Telephone ____________________________ DOB ____________________________ Sex ______ Age ______

IS EDP A MINOR? ☐ No ☐ Yes, If yes, Parent/Guardian must accompany child to ED.
If Yes, Parent/Guardian Name: ____________________________________________________________________

Parent Guardian Address: ☐ Same as EDP ☐ Other: ____________________________________________________________________

Homeless ☐ No ☐ Yes ☐ Unk

Interpreter Needed? ☐ No ☐ Unk ☐ Yes Specify Language ____________________________

What was reported to Police about the EDP’s behavior?

Name of Source: ____________________________ Phone Number of Source: ____________________________

Relationship to Subject:

Officer’s Observation of EDP’s behavior:

__________________________ ____________________________ ____________________________

Weapons Check: EDP Searched? ☐ No ☐ Yes Weapons Found? ☐ No ☐ Yes (specify) ____________

Disposition:

Potential for Violence? ☐ Y ☐ N

Restraints/Cuffs Used? ☐ Y ☐ N

A. Other agency/service involvement:

Current Mental Health /Service Providers: ☐ No ☐ Unk ☐ Yes

Providers Name: ____________________________ Agency: ____________________________

Phone No.: __________ Consulted? ☐ No ☐ Yes

B. MCAT Called? (732-6228) ☐ No, Reason: ____________________________

☐ Yes MCAT staff Name: ____________________________

Responded to scene? ☐ No

Response/Reason ____________________________

☐ Yes: if yes ,response time from time of call to arrival (duration minutes) ____________

C. FOR 22.09

Alternative safe location for client available? ☐ No ☐ Unknown ☐ Yes

Comments: ____________________________

Addiction Crisis Center Contacted (ACC) (735-1645) Called? ☐ NA

☐ No Reason: ____________________________

☐ Yes, Worker Name: ____________________________ Response/ reason for refusal:

OCDMH 9/16/09
BEHAVIORS/ACTIONS INDICATING THAT PERSON IS A DANGER TO SELF/OTHERS (CHECK ALL THAT APPLY):

☑ Places self in dangerous situations ☐ Unable to Care for Self ☐ Presence of weapons/dangerous
☐ verbal threats of harm to self ☐ Physical gestures of harm to self ☐ attempted to harm self
☐ verbal threats of harm to others ☐ Physical gestures of harm to others ☐ attempted to harm others

Specify

CHECK ALL BEHAVIORS OF EDP THAT ARE EITHER OBSERVED (O) OR REPORTED (R):

O R VERBAL /BEHAVIORAL O R APPEARANCE AND BEHAVIOR
☐ ☐ INCOHERENT/ILLOGICAL SPEECH ☐ ☐ CONFUSED/DISORIENTED
☐ ☐ TALKING TO SELF ☐ ☐ SAD EXPRESSION/CRYING
☐ ☐ FAILURE TO RESPOND TO QUESTIONS ☐ ☐ PRESENCE OF FECES/URINE
☐ ☐ REPORTED HEARING VOICES ☐ ☐ BLOODSHOT EYES
☐ ☐ SLURRED SPEECH ☐ ☐ SUSPICIOUSNESS
☐ ☐ EXTREME RAPID/UNCONTROLLED SPEECH ☐ ☐ HYPERACTIVITY
☐ ☐ EXTREME SLOW SPEECH ☐ ☐ NODDING OUT
☐ ☐ HOSTILE/AGRUMENTATIVE BELLIGERANT ☐ ☐ PROFUSE SWEATING
☐ ☐ REPEATED LOUD YELLING ☐ ☐ APPEARS INSENSITIVE TO PAIN
☐ ☐ OVERLY SUSPICIOUS/FEELINGS OF PERSECUTION ☐ ☐ DRESS INCONSISTENT TO WEATHER
☐ ☐ TALKS REPEATEDLY ABOUT A SINGLE SUBJECT ☐ ☐ EXHIBITS EXTRAORDINARY STRENGTH
☐ ☐ EXPRESSES IDEAS OF INFLATED SELF-WORTH ☐ ☐ RAPID HEART RATE/RESPIRATION
☐ ☐ TALKS REPEATEDLY ABOUT DEATH

SUBSTANCe ABUSe INDICATORS

O R
☐ ☐ OPEN DRUG CONTAINERS
☐ ☐ ALCOHOL CONTAINERS
☐ ☐ CRACK VIALS
☐ ☐ GLASSINE ENVELOPES
☐ ☐ HYPODERMIC NEEDLES
☐ ☐ ADMITS TO/REPORTED USE OF(SPECIFY):__________
☐ ☐ OTHER DESCRIBE: __________________________

BREATHElIZER RESULT: __________________
Time of Test: _________ am pm

CRIMINAL CHARGES: Criminal Charges Placed? ☐ No ☐ Yes , Charge: __________________________
Appearance Ticket Issued? ☐ No ☐ Yes
Order of Protection in Force? ☐ No ☐ Yes Details: __________________________
IF EDP does not require Inpatient Psychiatric/Medical Services, should delivering police agency be notified prior to release? ☐ NO ☐ YES, Police Agency Contact Name/Number: __________________________

Time IN ED: _____ AM PM Time Out ED: ___________ AM PM

SIGNATURE of ED RN/MD releasing Law enforcement:

*****************************************************************************************
ROUTING: 1 COPY TO ED, 1 COPY TO LAW ENFORCEMENT, 1 COPY TO COUNTY COMMISSIONER OF MENTAL HEALTH: Oneida County MH fax: 798-6445/ Herkimer County MH Fax: 867-1469

Faxed to Director of Mental Health _____ Oneida _____ Herkimer
By __________________________ Officer Signature _____ Time
1. I, _______________________, a Police/Peace Officer of the _______________________, hereby acknowledge that I have taken into custody _______________________, residing at _______________________, Male - Female, DOB ______/______/______, who appears to be mentally ill and is conducting him/herself in a manner which is likely to result in serious harm to him/herself or others.

☐ I have removed or directed the removal of the person to BENEDICTINE HOSPITAL.
☐ Not taken into custody. For information purposes only

Print _______________________, DATE/TIME: _______________________

---

2. LOCATION OF INCIDENT: __________________________________________

3. DESCRIPTION OF INCIDENT: ______________________________________

---

4. NAME OF INFORMANT: ____________________________________________
   PHONE: _________________________________________________________

---

5. WHAT BEHAVIORS OR ACTIONS INDICATE THAT THE PERSON MIGHT BE A DANGER TO SELF OR OTHERS?

- [ ] Places self in dangerous situations
- [ ] Physical Threats
- [ ] Unable to care for self
- [ ] Talk of hurting/killing self/others
- [ ] Verbal threats
- [ ] Attempting to hurt/kill self/others
- [ ] Potential for "Suicide by cop"
- [ ] Assault/Violent Behavior
- [ ] Presence of weapons (Specify)

---

6. DOES THE PERSON SHOW ANY OF THE FOLLOWING BEHAVIORS? (Check box if behavior was observed (O) or reported (R).

- [ ] Incoherent speech
- [ ] O Arguementative
- [ ] O Talk of death
- [ ] O Statements of self-importance
- [ ] O Presence of feces or urine
- [ ] O Hearing voices
- [ ] O Bloodshot eyes
- [ ] O Needle marks
- [ ] O Hostile/Belligerent
- [ ] O Other (describe briefly)
- [ ] O Drug Paraphernalia (Specify)
- [ ] O Prescription Drug (Specify)
- [ ] O Suspicious/Paranoid
- [ ] O Hyperactive
- [ ] O Drowsiness
- [ ] O Profuse sweating
- [ ] O Insensitive to pain
- [ ] O Inappropriate dress/disheveled
- [ ] O Extraordinary physical strength
- [ ] O Alcohol containers

---

7. OFFICER'S COMMENTS/OBSERVATIONS: ________________________________

---

8. CRIMINAL CHARGES PENDING: [ ] Yes [ ] No

Charge(s) ____________________________

Appearance ticket issued: [ ] Yes [ ] No

Order of Protection (in effect): [ ] Yes [ ] No [ ] Unknown

Subject of Order: ____________________________

Name: ____________________________

Relationship: ____________________________

---

9. POLICE NOTIFICATION OF EDP'S ADMISSION OR RELEASE

Police Contact: ____________________________

Tel. No.: ____________________________

Time Notified: ____________________________

By Whom: ____________________________

---

10. ER STAFF REC'D EDP: ____________________________ Date/Time: ____________________________

Print Name: ____________________________

Distribution: White - Police Agency  Yellow - to Receiving Hospital
Appendix 2

Police Mental Health Training in NYS
Brief Review of Police Mental Health Training Available in NYS

The Police Mental Health Coordination Project, co-administered by the NYS OMH Division of Forensic Services and the NYS Division of Criminal Justice Services Office of Public Safety, prepares law enforcement officers to assess and intervene with persons suffering emotional disturbance. The Project consists of several training-related components, as described below.

The first is a two-day mental health training curriculum designed to meet the NYS requirements for recruit level officers. As detailed on the NYS OMH website the Police Mental Health Recruit Training is designed to enable police officers to identify the indicators of emotional disturbance, to understand the causes of emotional disturbance, to appreciate the experience of mental illness, to utilize NYS Mental Hygiene Law, to make effective assessments and interventions, and to appropriately document their actions. This curriculum is delivered in police academies in New York.

In recognition of the fact that most police officers do not have an opportunity for any refresher or updated training since graduating from the academy, an in-service curriculum called Responding to Situations Involving Emotionally Disturbed People was developed in 2005. Although the in-service can be completed in one day, the training modules were intentionally designed to afford flexibility in their delivery. Thus, Departments who identify specific needs for refresher training, but may not have a full day available are able to ‘pick and choose’ modules to fit the time allotted.

To prepare trainers, the OMH Division of Forensic Services in conjunction with NYS DCJS, sponsors Train-the-Trainer programs. Taught by experienced “master trainers” (both mental health clinicians and police officers) the Train-the-Trainer programs review the curriculum content and focus on training strategies. Both the recruit training and the in-service curriculum are designed to be co-taught by a mental health professional and law enforcement personnel.

At about the same time that the NYS OMH Division of Forensic Services and the NYS DCJS Office of Public Safety began their collaboration to create the training programs for police academies across New York (in the late 1980’s), the Police Department in Memphis, Tennessee developed a Crisis Intervention Team (CIT) after officers shot and killed a man with mental illness. A CIT is a specialized team of police officers that have received additional training (usually 40 hours) on mental health-related issues. The overall CIT program involves ongoing collaboration with consumer and family advocacy groups (e.g., local chapters of NAMI and/or the Federation of Families for Children's Mental Health) and the public mental health system. A proliferation of communities across the nation have adopted the “Memphis model” and created a specially trained cadre of police officers who are called upon to respond to citizens experiencing emotional crises. Although there have been no controlled studies to date, program evaluations have shown good outcomes (i.e., lower arrest rates, increased referrals for treatment, decreased use of force, and less officer and citizen injuries).
While many other states have developed an extensive network of Crisis Intervention Teams, New York has lagged behind. Nevertheless, as CIT becomes a standard in police departments, there is increasing interest across the New York law enforcement community to create CITs. Rochester created the first CIT in NYS in 2004. Several other departments have created similar programs and others are currently in the planning stages.

In response to increased interest in mental health-related training by NYS law enforcement officials, the NYS Division of Criminal Justice Services Office of Public Safety (in collaboration with the NYS OMH Division of Forensic Services) offered Crisis Intervention Officer Training (CIOT) four times in 2006 and twice in 2007 (Additional trainings have since been offered in Westchester County). Representatives from multiple departments attended these regional week-long courses based on the Rochester CIT curriculum. Although designed for road patrol, other affiliated entities were invited to attend. Thus, staff from Probation, Parole, Corrections and college safety officers attended in addition to police officers and sheriff’s deputies.

After the Virginia Tech tragedy in April, 2007, the State University of New York (SUNY) expressed an interest in having their police officers receive additional training in the assessment and intervention of students with mental illness. Based on CIOT, a 2-day training (Anxiety Indicators in a Campus Environment) was delivered to several SUNY campuses in 2007 and 2008.

In the summer of 2011 the Police-Mental Health Crisis Intervention Network (PMHCIN) was formed. This organization is devoted to promoting development and improvement of specialized policing responses to individuals with mental illness in New York. The network is actively seeking input and collaboration from all interested stakeholders including those that are currently affiliated with (or hope to develop) a Crisis Intervention Team (CIT), a law enforcement-mental health co-response program, and/or other police-involved jail diversion approaches. For more information, please contact Don Kamin, Ph.D., Chief, Clinical & Forensic Services at the Monroe County Office of Mental Health, via e-mail (dkamin@monroecounty.gov).
Appendix 3

Policy & Procedure for Appointing DCS Designees
Monroe County

Director of Community Services Designee
Memorandum of Understanding
Ontario County
Monroe County Office of Mental Health

Policy & Procedure for Appointment of Director of Community Services Designees

Section 1: Policy for Appointments

Pursuant to Sections 9.37 and 9.45 of NYS Mental Hygiene Law, the Director of Community Services has the authority to appoint designees to act on his or her behalf. Specifically, Section 9.37 designees are empowered to determine whether individuals are in need of immediate inpatient care. (The need for immediate hospitalization needs to be confirmed by a staff physician of the hospital prior to admission). Section 9.45 designees are empowered to direct the removal of any person, within that jurisdiction, to a 9.39 hospital.

The Director of the Monroe County Office of Mental Health / the Director of Community Services for Monroe County shall make Director of Community Services designees (DCS designees) in accordance with the following guidelines:

A. DCS designees pursuant to Section 9.37 of NYS Mental Hygiene Law shall be psychiatrists (NYS licensed physicians who are, or eligible to be certified by, the American Board of Psychiatry and Neurology). Exceptions to this rule will be made on a case-by-case basis.

B. DCS designees pursuant to Section 9.45 of NYS Mental Hygiene Law shall include all DCS designees made pursuant to Section 9.37 of NYS Mental Hygiene Law and individuals working on the Rochester Community Mobile Crisis Team who meet the criteria (under the Codes, Rules, and Regulations of New York State, Part 102.6) to be a Director of Community Services. Such individuals shall be currently licensed psychologists, certified social workers, or master's level psychiatric mental health nurses and be currently licensed as registered nurses. The individual must have obtained a degree from a college or university recognized by the NYS Education Department.

C. Nurse Practitioners in Psychiatry and other individuals who are in supervisory positions are eligible to apply for DCS designee status provided they meet the requirements as specified in paragraph B above. The sponsoring agency needs to explain why these additional individuals are needed as designees.

D. Other individuals shall be appointed as Section 9.45 DCS designees who are in key clinical oversight positions for the County Office of Mental Health provided the Director of Community Services determines they have the requisite skills needed to responsibly carry out the duties under MHL Section 9.45. Examples of such positions include, but are not necessarily limited to, the Chief of Clinical and Forensic Services for the County Office of Mental Health, the Manager of the Monroe County Socio-Legal Center, and the Manager of Assisted Outpatient Treatment.

Section 2: Procedure for Appointments

A. Public mental health agencies shall contact the Monroe County Office of Mental Health and submit names and credentials of individuals who they request to be appointed DCS designees. The submission of such a name by a public mental
health agency signifies that all such individuals are in good standing with the agency under which their name is being submitted (i.e., that all such individuals are duly licensed and/or credentialed, that there are no disciplinary actions and/or malpractice suits pending due to concerns about clinical decision-making), and that they have reviewed and understand the pertinent sections of Mental Hygiene Law.

a. Upon request, Monroe County Office of Mental Health personnel is available for in-service training.

B. Upon receipt and review of submissions, the Monroe County Office of Mental Health will notify the agency of the decision to appoint individuals as DCS designees.

C. It will be the responsibility of the mental health agencies that submitted names to the Monroe County Office of Mental Health to inform the Office when those individuals are no longer working at that agency. When this occurs, the Office will remove them from the list of approved DCS designees associated with that agency. In addition, should an individual no longer want to be a DCS designee, that individual should contact the Office directly to have his or her name removed from the list.

Section 3: Responsibilities of Appointees

A. DCS designees are responsible for knowing the pertinent sections of Mental Hygiene Law under which they are carrying out DCS designee responsibilities and are required to act in accordance with Mental Hygiene Law and all other relevant Laws and Regulations.

B. In the course of carrying out DCS designee responsibilities, if the designee gains knowledge of systemic issues that he or she believes should be brought to the attention of the Monroe County Office of Mental Health, the designee should contact the Director or the Chief of Clinical and Forensic Services.

C. The DCS designee should be aware that the appointment as a DCS designee was made through a public mental health agency and as such, when that individual leaves that agency, he or she will no longer be an approved DCS designee. Exceptions to this include individuals who have been appointed a DCS designee through another agency.

Section 4: Community Verification of DCS Designees

A. Law enforcement is informed that they can call Life Line or 911 for verification of an individual’s DCS designee status. Thus, it will be the responsibility of the Monroe County Office of Mental Health to provide Life Line and 911 with accurate up-to-date lists of DCS designees.

8/28/06
Revised 7/22/11
DIRECTOR OF COMMUNITY SERVICES
DESIGNEE
MEMORANDUM OF UNDERSTANDING

AUTHORITY: Under Article 9 of the Mental Hygiene Law the Director of Community Services has the authority to designate individuals to act in his/her stead in effectuating a removal as described above. The designee is under the same legal obligations and must perform his/her duties to the same standard as the director.

PURPOSE: This MOU appoints a qualified professional as a Designee of The Director of Community Services for the County of Ontario, New York and establishes an understanding of what the duties, responsibilities and parameters are for a Designee when s/he is overseeing the involuntary removal of a person under Article 9 of the Mental Hygiene Law.

PARTIES: This MOU is entered into by and between:

Director:
William M. Swingly, LCSW-R, ACSW
Director of Community Services
Ontario County Mental Health Dept.
3019 County Complex Drive
Canandaigua, NY 14424

AND

Designee Appointee:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

CREDENTIALS: Prior to appointment, the Designee shall provide the Director with copies of the following credentials:

☐ Curriculum Vitae
☐ Medical Degree
☐ NYS License
☐ NYS Registration
☐ DEA Registration
☐ Evidence of a negative State Central Register Database check by NYS Office of Children and Families

AND
Shall submit copies of periodic registration renewals, thereafter.
DUTIES: The Designee agrees to perform the following duties according to the specified procedures.

☐ Be an applicant for involuntary admission on medical certification (known as 2PC),
(Section 9.27 Mental Hygiene Law)

This function would usually not be performed by a designee who is a physician because the applying physician cannot also be one of the two physician examiners. To use an MD as applicant would require three MD’s, one separate applicant plus two examiners. [NOTE: Standard for admission on Form OMH471 (MH-11/97) and 471A (MH-2/94)]

Forms used:
- OMH471(MH-11/97) = Application for Involuntary Admission on Medical Certification.
- OMH471A(MH-2/94) = Certificate of Examining Physician – two certificates required. Examination of patient can be completed concurrently by two physicians or separately as circumstances dictate.

Reports to the Director of Community Services
Copies of completed OMH471(MH-11/97) and OMH471A(MH-2/94) must be forwarded to the Director of Community Services as soon as possible after the procedures. Forms may be faxed to 585-396-4993 or mailed to:

Ontario County Mental Health Department
3019 County Complex Drive
Canandaigua, NY 14424

☐ Be an applicant for involuntary admission on Certificate of a Director of Community Services or Designee.
(Section 9.37 Mental Hygiene Law)

The designee makes application and examines the alleged mentally ill subject. [NOTE: Standard for admission on Form OMH475(MH-3/06) and 475A(MH-5/03)]

Forms used:
- OMH475(MH-3/06) – Application for Involuntary Admission by the Director of Community Services or Designee
- OMH475A(MH-5/03) = Certificate of Examination by Director of Community Services or Designee
Reports to the Director of Community Services:
Copies of completed OMH475(MH-3/06) and OMH475A(MH-5/03) \textbf{must} be forwarded to the Director of Community Services as soon as possible after the procedures. Forms may be faxed to 585-396-4993 or mailed to:

Ontario County Mental Health Department
3019 County Complex Drive
Canandaigua, NY 14424

Emergency or CPEP (Comprehensive Psychiatric Emergency Program)
Custody/Transport of a person alleged to be mentally ill to a hospital approved to receive emergency or CPEP emergency admissions.
(Section 9:45 Mental Hygiene Law)

The designee requests a pick up by a law enforcement agency or an ambulance service of an alleged mentally ill person based upon a report of a third party in the community. The qualified parties are listed on the form (OMH474A/476A(MH-6/08)). [NOTE: Standard for “Likely to result in serious harm to him/herself or others” at the * on the bottom of the form.]

Forms Used:
OMH474A/476A(MH-6/08) – Emergency or CPEP Emergency Admission. Section II of the form applies to the designee.

Reports to the Director of Community Services:
Copies of completed OMH474A/476A(MH-6/08) \textbf{must} be forwarded to the Director of Community Services as soon as possible after the procedures. Forms may be faxed to 585-396-4993 or mailed to:

Ontario County Mental Health Department
3019 County Complex Drive
Canandaigua, NY 14424
NON-DELEGATION: This designation cannot be delegated, by the designee, to any other party.

IMMUNITY: The Designee has qualified immunity **only** when acting in his/her capacity as an agent of the Director AND only after establishing **probable cause** to remove the person to the hospital or comprehensive psychiatric emergency program. As a Designee you agree not to hold yourself out as, or claim to be, an officer or employee of the County by reason of your designation.

REVIEW: This designation, along with the Designee’s credentials, will be subject to periodic review and may be terminated at any time according to the procedure noted below.

TERM: This Memorandum of Understanding is effective upon the day and date signed and executed by both the Director of Community Services and the Designee and shall remain in effect until terminated in writing by either party. Such written notice shall be delivered by hand or certified mail to the addresses listed above.

_______________________________   __________________
William M. Swingly, LCSW-R, ACSW    Date
Director, Community Services

_______________________________   __________________
Date

ATTACHMENTS:

OMH471 (MH-11/97)–Application for Involuntary Admission on Medical Certification
OMH471A (MH-2/94)–Certificate of Examining Physician
OMH475 (MH03/06)–Application for Involuntary Admission by the Director of Community Services or Designee
OMH475A (MH-5/03)–Certificate of Examiner by Director of Community Services or Designee
OMH474A/476A (MH-6/08)–Emergency or CPEP Emergency Admission

Original filed Ontario County Mental Health   Copy to Designee
October 8, 2008
Appendix 4

Releasing Individuals from Custody for the Purpose of Hospitalization

An Example from Monroe County
Inmate in need of Psychiatric Hospitalization

Felony and/or concerns about Violence?

YES: Refer to Forensic Unit

NO: Jail or defense counsel contacts Judge to request transfer to hospital for evaluation for admission

NO: Judge agrees?

NO: Jail Medical/Mental Health staff notifies ED; Sheriff’s Deputies transport to hospital

YES: Judge writes order for transport to hospital: release from custody when hospitalized. Court appearance scheduled for 7 – 10 days

Release from custody: Monitoring by Pre-Trial Enhanced Supervision; Judge, DA, PD, & Probation notified by Pre-Trial re: release & court date

Decision to Admit?

YES: Individual discharged from hospital; Pretrial continues to monitor until Court date. Pre-Trial notifies Judge, DA, PD, & Probation of discharge.

NO: Transport back to jail

Consider for Forensic Unit admission

6/26/06
Appendix 5

CPL 730 Examination Testing Procedures

And

A Review of Forensic Assessment Instruments

Courtesy of Broome County Department of Mental Health

Attorney’s Questionnaire

Courtesy of Onondaga County

Managing Criminal Procedure Law 730 Bed Utilization

Orange County Lean Six Sigma Project
Broome County Mental Health Department

CPL 730 Examination Testing Procedures

Psychology staff at BCMHD are currently using three instruments as they conduct CPL 730 Exams. All of these instruments are standardized, normed referenced measures which have been designed specifically for purpose of evaluating individuals for competency to stand trial. Psychometric properties support their reliability and validity. These include:

**The MacArthur Competence Assessment Tool-Criminal Adjudication (MacCat-CA)** by Steven K Hoge, MD; Richard L. Bonnie, LLB; Norman Poythress, Ph.D.; John Monahan, Ph.D.

- Used to assess competency for individuals with mental illness

**Competence Assessment for Standing Trial for Defendants with Mental Retardation (CAST-MR)** by Caroline T. Everington, Ph.D. and Ruth Luckasson, J.D.

- Used to assess competency for individuals with predominately mental retardation

**Inventory of Legal Knowledge** by Randy Otto, Ph.D.; Jeffrey Musick, Ph.D.; Christina B. Sherrod, Ph.D.

- Used to assess faking bad or malingering for individuals participating in competency to stand trial examinations.

Note:
In addition to administering these instruments, a clinical interview is conducted and often a mental status examination is given. The client is observed interacting with their defense attorney, whenever possible.

For more information contact:
Robert Russell, Ed.D., Psychologist
Broome County Mental Health Department
229-331 State Street
Binghamton, NY 13903
607-778-1118
rrussell@co.broome.ny.us
Review of Forensic Assessment Instruments


- **Authors:** Poythress, N., Nicholson, R., Otto, R., Edens, J., Bonnie, R., Monahan, J., & Hoge, S.
- **Description**
  - Developed to assess abilities associated with adjudicative competence (i.e. defendant’s competency to proceed, assist counsel, make competent decisions).
  - 22 item structured and standardized interview. Takes 25 minutes to 1 hour to administer.
  - Organized into 3 parts called Understanding, Reasoning, and Appreciation
  - Understanding (basic comprehension of relevant facts):
    - 8 items based on a brief vignette regarding 2 men who get into a fight at a pool hall. One man is arrested, and faces charges and a trial process.
    - the 8 items ask questions regarding examinee’s comprehension of a) roles of defense and prosecution attorneys; b) the elements of an offense with which the defendant could be charged; c) elements of a lesser included offense; d) role of the judge; e) role of the jury; f) the consequence of conviction; g) consequences of pleading guilty; h) rights waived when one pleads guilty
    - Items can be “taught” using a standardized process if examinee fails to give an adequate response
  - Reasoning (refers to the ability to process info in the course of decision making):
    - 5 items offer 2 “facts” about the bar fight incident and ask the examinee which of the 2 would be more important for the defendant to tell his lawyer. 3 items are based on a description of 2 pleading choices (e.g. pleading guilty under a plea agreement, pleading not guilty and going to trial).
    - Items focus on decision making process, rather than the decision
      - whether the examinee seeks more info before deciding, offers an advantage and disadvantage for the chosen option, and manifests evidence of having compared the chosen option to the rejected option
  - Appreciation (rational awareness of the meaning and consequences of the proceedings in one’s own case):
    - 6 items based on the examinee’s own legal situation.
    - The examinee is asked whether compared to other people who are in trouble with the law if the examinee thinks he/she is more likely, less likely, or as likely to: a) be treated fairly in the legal process; b) be assisted by defense counsel; c) fully disclose case info to his/her defense attorney; d) be found guilty; e) get the same punishment as others if found guilty; f) plead guilty
    - Next, the examinee is asked to explain their choice, and queries are made to determine if the explanation contains evidence of “unrealistic beliefs that defendants have about themselves or their situations such as they are clearly implausible and colored by symptoms of mental illness.
    - Items are scored based on the explanation provided
- Scoring:
  - Responses are scored objectively (adequate, questionable, inadequate) using scoring criteria in the manual. There is no total MacCAT-CA score, rather scale scores.
  - Scale scores are compared to norms of 3 groups of adult defendants ages 18-65, half Caucasian, 90% male, from sites across the country: (1. jail inmates presumed competent, 2. defendants with mental illness but presumed competent, 3. defendants with mental illness but found incompetent to stand trial.)
  - Provides cut-off points to describe the degree of deficits or strengths (e.g. minimal or no impairment, mild impairment, clinically significant impairment)

- **Pros**
  - Assesses competence to assist counsel and decisional competence
  - Anchored in law and psycholegal concepts for structuring the assessment of relevant abilities for legal competence
  - Its structure makes the MacCAT-CA excellent for use as a clinical or research tool
  - High interrater reliability, good internal validity,
  - One of the 1st instruments to offer meaningful norms for comparing defendants whose competence to stand trial is in question

- **Cons**
  - Does not collect info on all of the abilities and deficits that might be relevant for competence to stand trial evaluations
  - Relies of defendant’s responses to hypothetical cases, thus it does not provide a means for comparing individuals’ abilities to actual demands of their situations
  - Reduces examiner’s ability to explore issues specific to the defendant
  - MacCAT-CA should be supplemented with mental status exam and unstructured interview of defendants competence
  - May not be generalizable to women given that very few women were involved in the normative sample
**Fitness Interview Test-Revised (FIT-R) (1998)**

- **Authors:** Roesch, R., Zapf, P., Eaves, D., & Webster C.
- **Description**
  - Designed to assist clinicians in obtaining info on all important aspects of fitness to stand trial, while recognizing the importance of clinical opinion and the relevance of information from other measures and sources
  - 70 item semi-structured interview. Takes about 30 minutes to administer.
  - Organized into 3 sections that assess factual knowledge of criminal procedure, appreciation of personal involvement in and importance of the proceedings, and ability to communicate with counsel and participate in defense
  - Factual knowledge of criminal procedure:
    - Assesses understanding of: 1) arrest procedure; 2) the nature and severity of current charges; 3) role of key participants; 4) legal process; 5) pleas; 6) court procedures
  - Appreciation of personal involvement in and importance of the proceedings
    - Assesses: 1) appreciation of the range and nature of possible penalties; 2) appraisal of available legal defense; 3) appraisal of likely outcome
  - Communicate with counsel and ability to participate in defense
    - Assesses capacity to: 1) communicate facts to lawyer; 2) relate to lawyer; 3) plan legal strategy; 4) engage in own defense; 5) challenge prosecution witnesses; 6) testify relevantly; 7) manage courtroom behavior
- **Scoring:**
  - Responses are subjectively scored (2-severe impairment of ability, 1-moderate impairment of ability, 0-little or no impairment of ability) at the end of the interview based on the examiner’s opinion of the examinee’s responses
  - An overall judgment of fitness score is calculated at the end of the interview. Examinee is classified as Fit, Questionable, or Unfit.
- **Comparison to MacCAT-CA**
  - Both focus on understanding of info about charges, penalties, and legal process, and have considerable content overlap
  - Both assess reasoning, or the defendant’s ability to make inferences about the importance of facts that might be relevant to communicate to counsel. However, the FIT-R’s questioning is much broader.
  - Both assess appreciation, or whether the defendant has a realistic perception of the penalties, possibilities, for defense, and outcome.
  - FIT-R focuses on the defendant’s own circumstances rather than hypothetical situations
  - FIT-R’s questions are more diverse regarding the nature of the defendant’s abilities
  - MacCAT-CA’s more narrow and more highly standardized format allowed for the development of highly objective scoring criteria, FIT-R uses opinion ratings
- **Pros**
  - Examinee allowed to probe regarding examinee’s answers in order to get clarification
  - Most of the concepts assessed in the interview are relevant for U.S. definitions of competence to stand trial
- **Cons**
  - Specific examples of responses or scoring criteria not provided
  - Does not provide norms
  - Modest interrater reliability, moderate construct validity
Competence Assessment for Standing Trial-Mental Retardation (CAST-MR) (1992)

- **Authors:** Everington, C. & Luckasson, R.

- **Description**
  - Developed to respond to needs that were considered unique for defendants with mental retardation
  - 50 item standardized, structured interview
  - Organized into 3 sections that assess Basic Legal Concepts, Skills to Assist Defense, and Understanding Case Events
  - I Basic Legal Concepts:
    - 25 questions that focus on assessing the defendants’ knowledge of the criminal justice process. Questions focus on the roles of several of the persons in trials, the meanings of words or concepts, the meanings of certain functions. Each of the questions has 3 multiple choice response options.
  - II Skills to Assist Defense:
    - 15 questions addressing defendants’ understanding of the client-attorney relationship. Questions are posed as “What if____” and “Let’s pretend____”. Each of the questions has 3 multiple choice response options.
  - III Understanding Case Events:
    - Consists of 10 open-ended, very brief questions focusing on the defendants’ ability to discuss the facts concerning the incident in a coherent manner and to understand the relationship between the alleged facts in the case and the subsequent arrest and charges.
  - Scoring:
    - Responses in sections I and II require assigning 1 point for correct answers. Responses in section III are scored according to a more detailed set of criteria provided in the manual (0, .5, or 1 credit). Total scores may be calculated up to 50 points.

- **Pros**
  - Examinees are given practice questions prior to each section to ensure they can understand and manage the response format
  - The manual provides instructions on how to manage cases in which examinees have difficulty grasping the nature of the task
  - A form is given to examinees on which the questions and multiple choice items are presented visually
  - Questions may be repeated and prompts may be given
  - Vocabulary and syntax are kept simple (2nd to 6th grade level), and a multiple choice format are used
  - Provides norms for individuals with and without MR, interrater reliability is good, test retest reliability is strong, internal consistency is good

- **Cons**
  - The multiple choice format is not consistent with the expressive and receptive language abilities that are needed during trial participation
Georgia Court Competence Test-Mississippi State Hospital (GCCT-MSH) (1988)

- **Authors**: Wildman, R., Batchelor, E., Thompson, L., Nelson, F., Moore, J., Patterson, M., & deLaosa, M.

- **Description**
  - Intended to provide a rapid, quantitative measure of the knowledge and skills necessary for competence for trial
  - 21 item standardized questionnaire. Takes about 10 minutes to administer.
  - Organized into 6 categories:
    1. Picture of the Court: Questions focus on the examinee’s description of the location of participants in the courtroom (i.e. where the judge and witnesses will sit)
    2. Functions: Questions inquire about the functions of the judge, jury, defendant’s lawyer, prosecutor, witnesses, the defendant, and people watching the trial
    3. Charge: Questions ask what is the charge and what the charge means to the examinee
    4. Helping the Lawyer: Questions ask about examinee’s plans to help the lawyer in defense, and assess the examinee’s knowledge of how to contact his/her lawyer
    5. Alleged Crime: Asks the examinee to describe what actually happened about the charge he/she is accused of
    6. Consequences: Asks what the examinee expects will be done to him/her if found guilty

- **Scoring**
  - Maximum points possible for each item varies. Total possible points is 50. Brief scoring criteria are provided for questions with no right or wrong answer. Points are multiplied by 2 to obtain a total score between 0 to 100. 69 or below suggests possible incompetence.

- **Pros**
  - A brief screen of incompetence
  - Inter-rater reliability is high, good internal consistency. No studies found on test-retest reliability
  - Strong criterion-related validity

- **Cons**
  - No norms, but mean scores from one study are available
  - Over-predicts incompetence (high false positive rate)
  - Only 71% sensitive to incompetence, thus more than ¼ of individuals who are incompetent would fail to be detected as incompetent
  - Does not assess the trial situation facing the examinee
  - Test domains and format derived based on authors’ perceptions of what should be included rather than empirically
Competence to Stand Trial Assessment Instrument (CAI) (1973)

- **Authors**: McGarry, A. L., and Associates, Laboratory of Community Psychiatry, Harvard Medical School

- **Description**
  - Developed to deliver clinical opinion to the court in language, form, and substance sufficiently common to the disciplines involved to provide a basis for adequate and relevant communication. Purpose is to standardize, objectify, and quantify, the relevant criteria for competence to stand trial.
  - Via interview the instrument assesses 13 functions related to a defendant’s ability to cope with the trial process in an adequately self-protective fashion via interview
  - 13 functions:
    1. Appraisal of available legal defenses;
    2. Unmanageable behavior;
    3. Quality of relating to attorney;
    4. Planning of legal strategy including guilty pleas to lesser charges where pertinent;
    5. Appraisal of role of individuals involved in the trial process;
    6. Understanding of court procedure;
    7. Appreciation of charges;
    8. Appreciation of range and nature of possible penalties;
    9. Appraisal of likely outcome;
    10. Capacity to disclose to attorney available pertinent facts surrounding the offense;
    11. Capacity to realistically challenge prosecution witnesses;
    12. Capacity to testify relevantly;
    13. Self-defeating vs. self-serving motivation
  - Clinicians encouraged to be flexible and with questioning
  - Scoring:
    - Each response is rated on a scale of 1 (total lack of capacity to function) to 5 (no impairment) or 6 if data is insufficient to make a determination. A total score is obtained for each function, however the 13 functions are not summed for an overall score. Thus, conclusions are drawn about the examinee’s competence in each domain.

- **Pros**
  - Examination and scoring should take no more than 1 hour for defendants in good contact with reality
  - Development of the test involved input from lawyers, psychiatrists, and psychologists

- **Cons**
  - 13 functions derived logically rather than empirically
  - Biased against persons who, for political or personal reasons, don’t have confidence in the criminal trial process, and bias due to examiner assumptions about the general nature of trial circumstances and attorney performances, to which a defendant’s response about specific attorneys or trial circumstances may be compared unfairly
  - No instructions, no criteria for provided each of the 1 to 5 ratings, no norms
  - Interrater reliability variable given lack of instructions for administration and scoring
  - Meager evidence for construct validity (more research needed)
  - More often used as a qualitative interview rather than a quantitative, scoreable instrument
  - Does not systematically assess the examinee’s current trial circumstances or attorney relations using any particular guidelines
Competence Screening Test (CST) (1973)

- **Authors:** Lipsitt, P., & Lelos, D., with McGarry, A. L., and Associates, Laboratory of Community Psychiatry, Harvard Medical School

- **Description**
  - Intended as a brief, psychometric instrument that would help decide whether more extensive assessment for competence to stand trial was needed. Purpose is to identify persons who clearly are competent to stand trial.
  - Developed by a team of lawyers, psychiatrists, and psychologists. A companion to the Competence to Stand Trial Assessment Instrument (Meant to be administered in conjunction with a brief psychiatric interview).
  - The test seeks to measure 3 constructs:
    1. the potential for a constructive relationship between the client and his/her lawyer, 2. the client’s understanding of the court process, and 3. ability to deal emotionally with the criminal process.
  - Consists of 22 items, each of which is the beginning of an incomplete sentence (i.e. “The lawyer told Bill that___”, “When I go to court the lawyer will____”)
  - Scoring:
    - Each sentence completion is scored according to 22 sets of definitions and examples provided in the manual. Each response is scored 2, 1, or 0 along 2 dimensions - legal criteria and psychological criteria. Scores are summed to arrive at a total CST score (range 0-44). A score below 20 raises the question of incompetence.

- **Pros**
  - Standardized instructions and scoring criteria.
  - Development of the test involved input from lawyers, psychiatrists, and psychologists
  - Interrater reliability high for experienced and inexperienced administrators.
  - Internal consistency is high

- **Cons**
  - No norms, but mean scores are available for certain populations.
  - Does not assess defendant’s knowledge or ability in relation to the demands of his/her own trial circumstances
  - High false positive rate
  - Despite the authors claims that the constructs involved in designing the test represent the Dusky standards, the legal constructs in Dusky are different from the measurements constructs of the CST
  - That an equal number of test items is provided for each measurement construct indicates that each construct should be given equal weight in all cases, although each case is different
  - The wording of some items may result in interpretive error
  - Sometimes it is difficult to distinguish between 2,1, and 0 point responses.
ATTORNEY’S QUESTIONNAIRE

TO (Client’s Attorney): _________________________________________________________________

FROM: (Evaluator):__________________________________________  DATE:___________________

Your client, ______________________ (Docket #_____________) has been referred to me for evaluation of competency to stand trial. I would greatly appreciate your completion of the following form, which will provide valuable assistance in beginning the evaluation. Please do not hesitate to contact me if you have any questions not covered here. My contact information is as follows:

Telephone:_________________ Fax:__________________ email:_______________________________

Agency & Address:_____________________________________________________________________

Who brought your client’s competency to the attention of the court?

☐ Myself  ☐ Prosecuting attorney  ☐ Court’s own motion  ☐ Probation Officer

☐ Detention Staff  ☐ Arresting officers  ☐ Other: ______________________________

What historical factors, if any, contributed to the perceived need for a competency evaluation?

Check all that apply  Describe factors checked

☐ History of mental illness
☐ History of psychiatric medication
☐ History of psychiatric hospitalization
☐ History of counseling/therapy
☐ History of mental retardation
☐ History of learning problems
☐ Other

One aspect of competency is the client’s understanding of the charges and possible dispositions associated with them. To help me assess this, please describe:

The charges against your client: __________________________________________________________

The nature of the dispositions that your client might face, given these charges and your client’s past record (optional): ______________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please describe any collateral consequences or added stressors in the client’s life that I should consider when interacting with this client: ____________________________________________

(over)
Another aspect of competency is the client’s ability to assist counsel and to manage the attorney-client relationship in a way that does not detract from the opportunity to develop the defense. Below, please indicate any factors that you have seen detract from these objectives, and describe how.

Check all that apply

☐ Easily confused
☐ Detached or indifferent
☐ Depressed
☐ Hostile, aggressive, defiant
☐ Inattentive or distracted
☐ Immature, childlike
☐ Difficulty communicating things
☐ Difficulty understanding you
☐ Difficulty retaining information
☐ Disorganized speech
☐ Peculiar/Odd statements or beliefs
☐ Seeing/Hearing things not present
☐ Very bizarre behavior
☐ Other

Describe factors checked

☐ Have observed nothing detracting from attorney-client interaction.

Competency is, in part, a comparison of the client’s abilities to the demands of the client’s own case. Please describe the likelihood of the following demands of the client’s case (circle one response each):

1. Is likely to have to make a decision about a plea agreement.  
   Evidence against client is unclear and the defense largely depends on client ability to provide information.
   No  Unlikely  Don’t Know  Likely  Definitely

2. Case will involve many adverse witnesses.
   No  Unlikely  Don’t Know  Likely  Definitely

3. Client will need to testify in the case.
   No  Unlikely  Don’t Know  Likely  Definitely

4. The pre-adjudication process will be lengthy.
   No  Unlikely  Don’t Know  Likely  Definitely

5. The adjudication hearing will be lengthy.
   No  Unlikely  Don’t Know  Likely  Definitely

6. The adjudication hearing will be complex (e.g. difficult to follow, complicated evidence).
   No  Unlikely  Don’t Know  Likely  Definitely

Thank you for this information. Do not hesitate to contact me if you have any questions.
Managing Criminal Procedure
Law 730 Bed Utilization

Orange County
Lean Six Sigma Project
June 15, 2011

Glossary

- ADA – Assistant District Attorney
- CPL – Criminal Procedure Law
- HIPAA – Health Insurance Portability and Accountability Act
- LOS – Length of Stay
- MHFPC – Mid-Hudson Forensic Psychiatric Center
- MHLS – Mental Hygiene Legal Services
- NYSDOC – New York State Department of Corrections
- NYSOMH – New York State Office of Mental Health
- OCDA – Orange County District Attorney
- OCMH – Orange County Department of Mental Health
- OCJ – Orange County Jail
- PRN – as needed
Project Background

- Competency Examinations are ordered by the Orange County Local and Criminal Courts to determine if the defendant has the mental capacity to understand the charges that have been filed against him/her and whether he/she has the ability to relate with an attorney to provide for his/her defense. The most costly population to treat in hospital care expenses is the Court Orders of Commitment under Criminal Procedure Law 730 to Developmental Disabilities Facilities and New York State Office of Mental Health (NYSOMH) Forensic Hospitals. Under these orders individuals may serve up to two thirds of what their sentence would have been with a charge back to the County of 50% of the daily rate for the facility. The Orders of Commitment to the NYSOMH Forensic Hospital cost $414,318 in 2009, which is a 519% increase over 2006 expenses.
Problem Statement

- There is a three year trend in the increase of bed utilization days for individuals assessed to be incompetent to stand trial, hospitalized in New York State Office of Mental Health Forensic Hospitals. The project objective is to reduce average number of CPL bed days per person per year from a 3 year average of 77 days to 60 days. The financial impact will result in an annualized savings of up to $144,000.

Team Members

- Darcie Miller, Deputy Commissioner - Team Leader
- Meghan Keener, Forensic Coordinator - Process Owner
- Lori Eisloeffel, Fiscal Technician
- Chris Ashman, Commissioner - Champion
Scope and Scale

- Included:
  CPL bed days in New York State Office of Mental Health Forensic Hospitals

- Excluded:
  CPL bed days in New York State Office of Mental Retardation and Developmental Disabilities Secure Facilities.

SIPOC

<table>
<thead>
<tr>
<th>Suppliers</th>
<th>Inputs</th>
<th>Process</th>
<th>Outputs</th>
<th>Customers</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Court Judges</td>
<td>CPL 730 Evaluations</td>
<td>Evaluating Defendants</td>
<td>Competent Defendants</td>
<td>Judges</td>
</tr>
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<td>Jail Clinicians Evaluator</td>
<td>Clinical Intervention</td>
<td>Restoring Defendants to Competency</td>
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<td>District Attorney's Office</td>
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<td>State Forensic Hospital Personnel</td>
<td>Medication Compliance</td>
<td></td>
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<td>Defense Attorneys</td>
</tr>
<tr>
<td></td>
<td>Clinical / Psychiatric History</td>
<td></td>
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<td>Defendants</td>
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</tbody>
</table>


Operational Definition

- Measured competency of population served
  - A defendant is competent to stand trial if he/she:
    - Is oriented to time, place, person
    - Is able to perceive, recall, and relate
    - Understands the court process and critical roles
    - Can establish a working relationship with his attorney
    - Is sufficiently stable to withstand stresses of trial without suffering a prolonged or permanent decompensation
Baseline Data

- Reviewed bills received from NYSOMH Bureau of Forensic Services; verified the baseline data through review of defendant 730 files, Jail files, and MHFPC admission and discharge summaries.
- 3 year trend increase in bed utilization days

Data Collection Plan

Collected data for twenty defendants involved in the 730 process who were found incompetent and hospitalized in 2008 and/or 2009 (the case may have originated in 2007 and/or may continue through 2010). The team reviewed defendant 730 files, Jail files, and MHFPC admission and discharge summaries.

- Date of arrest
- Date seen in OCJ following date of arrest
- Date medication ordered in OCJ
- Admission and discharge dates at MHFPC
- County Court Judge
- Criminal Charge at arrest/indictment
- Psychiatric/Psychological evaluation recommendation for incapacity
Class D, a lower level felony, has the longest average length of stay, accounting for 4 of the 20 defendants.

The categories above are the primary competency criteria and were selected based on subjective review of the defendants records. Defendants experiencing psychosis accounted for the longest average length of stay and represented the majority of the defendants. One atypical defendant in the unable to assist attorney category has skewed the data due to an 825 day stay.
Multiple admissions accounted for the longest average length of stay and pose the greatest difficulty in restoring and maintaining competency.

Judge Berry has the longest average length of stay, accounting for 3 of the 20 defendants.
-50% of the defendants were seen by a Mental Health clinician at OCJ on the day of arrest. 80% of the defendants were seen within 6 days.
- Defendants that begin/continue a Mental Health treatment are more likely to establish/maintain capacity throughout the court process.

 Defendants not taking medication prior to commitment accounted for the longest average length of stay.
Analyze Phase

Managing Criminal Procedure
Law 730 Bed Utilization

Cause and Effect Diagram

OCMIDH 730 Evaluation
- Broad interpretation of CPL language
- Volatility used in determining capacity
- No diagnosis/impairment provided
- Error in side of caution
- Limited access to clinical history
- Evaluator recommendations
- Defendant malingering
- Defendant non-compliant

Legal System
- Delay processing/follow-up paperwork
- Delay scheduling 730 hearing
- Judge increases LOS
- Court calendar
- MHFS delays intervention
- District Attorney increases LOS
- Non-participation in resolution groups
- Refusal of medication: clinical treatment
- Defends increase LOS
- Refusal of medication: alternative med and treatment
- Delay med over objection
- Delay med over objection
- No ability med over objection
- Defendant refuses medication
- Court calendar
- Adjournments

OCJ
- NYSDOC policy
- Length of time to complete court process
- Adjournments
- Non-participation in resolution groups
- Refusal of medication: clinical treatment
- Defends increase LOS
- Refusal of medication: alternative med and treatment
- Delay med over objection
- Delay med over objection
- No ability med over objection
- Defendant refuses medication
- Court calendar
- Adjournments

MHFFC
- Financial gain
- No ability med over objection
- Defendant refuses medication
- Length of time to complete court process
- Adjournments
- Non-participation in resolution groups
- Refusal of medication: clinical treatment
- Defends increase LOS
- Refusal of medication: alternative med and treatment
- Delay med over objection
- Delay med over objection
- No ability med over objection
- Defendant refuses medication
- Court calendar
- Adjournments

High utilization of bed days
Root Cause Approach

- Created a Fishbone – Cause and Effect Diagram
- Completed the 5 Why's
- Completed Brainstorming Exercise

- Chris Ashman, Commissioner, OCDMH
- Darcie Miller, Deputy Commissioner, OCDMH
- Meghan Keener, Forensic Coordinator, OCDMH
- Lori Eisloeffel, Fiscal Technician, OCDMH
- Carmen Elizondo, Clinic Director, OCDMH Jail Clinic
- Clarise Williams, Social Worker, OCDMH Jail Clinic
- William Haas, Psychologist, OCDMH Consultant Evaluator
- Vega Lalire, Psychologist, OCDMH Consultant Evaluator
- Lynn Spuller, Forensic Coordinator, MHFPC
- David Huey, Executive ADA, OCDA
- Karen Edelman–Reyes, ADA, OCDA
- Dawn Mulder, Principal Attorney, MHLS
- Vincent Spizzo, Private Consultant

Example of 5 Why’s

High utilization of bed days:

- Why – Defendant not competent
- Why – Defendant not taking medication
- Why – Defendant refuses medication
- Why – No medication over objection at OCJ
- Why – NYS Department of Correction policy
Root Causes

- NYS Department of Correction policy regarding stat medication and/or PRN medication at OCJ
- NYSOMH legislation regarding medication over objections not eligible in county jails
- Length of time to schedule hearings in County Court
- Limited communication between 730 evaluators and Jail Clinic Staff
- Defendant non–compliance with treatment at OCJ and MHFPC
- Lack of ancillary information to inform competency decision by evaluators
- Defense Attorney significant impact on court determination of competency yet not required to specify reasons that match criteria under CPL
- Limited control over the 730 process

Improve Phase

Managing Criminal Procedure
Law 730 Bed Utilization
Potential Solutions

- OCDMH monitoring / managing 730 process
- Education re: 730 Law and process
- Training: engagement / intervention for Jail Staff re: 730 defendant
- Develop and implement a competency maintenance program in Jail
- Jail staff / 730 evaluators communicate re: diagnosis and course of treatment in Jail
- Education re: HIPAA Laws
- Uniform 730 report format
- 730 evaluators recall defendant if need to do additional testing / evaluation
- Consider having defense attorney present during the evaluation i.e. in NYC
- Get police report for all 730 defendants
- County Court to implement new process of returning defendant to Jail once found fit by MHFPC staff to await hearing
- Court orders to include access to obtain collateral info re: Mental Health history
- Pursue policy that would expedite court response to MHFPC request for medication over objection (utilize duty judge)
- On the spot evaluation at court when discrepancy
- Developing a Mental Health Court

Solution Evaluation

<table>
<thead>
<tr>
<th>Potential Improvement Impact</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability of Team to Make and Control Changes</td>
<td>- OCDMH monitoring / managing 730 process - Educate all parties re: 730 Law and process</td>
<td>- Training: engagement / intervention for Jail Staff re: 730 defendant - Develop and implement a competency maintenance program in Jail - Jail staff / 730 evaluators communicate re: diagnosis and course of treatment in Jail</td>
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<td>- County Court to implement new process of returning defendant to Jail once found fit by MHFPC staff to await hearing - Court orders to include access to obtain collateral info re: Mental Health history</td>
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</tr>
<tr>
<td>No Control</td>
<td></td>
<td></td>
<td>- Developing a Mental Health Court</td>
</tr>
</tbody>
</table>
Implemented Solutions

- Developed a policy and procedure for OCDMH monitoring / managing 730 process
- Provided education re: 730 Law and process to 730 evaluators, OCDMH administrative staff, and Jail Staff
- Provided training on 2/24/11: engagement / intervention for Jail Staff re: 730 defendant
- Developed and implemented a competency maintenance program in Jail and trained Jail staff on 2/24/11
- Jail staff / 730 evaluators communicate re: diagnosis and course of treatment in Jail
- Provided education re: HIPAA Laws to stakeholders
- Developed standardized 730 report format and trained 730 evaluators on 2/17/11
- Established a protocol for 730 evaluators to obtain consent from OCDMH to recall defendant if need to do additional testing / evaluation
- Established that CPL 730 allows for having defense attorney present during the evaluation and requires defense attorney be notified of evaluation date and time
- OCDMH policy requires police report be obtained for all 730 defendants prior to evaluation
- County Court implemented new process of returning defendant to Jail once found fit by MHFPC staff to await hearing
- When Forensic Coordinator finds discrepancy between parties regarding defendant’s competency, may recommend on the spot evaluation at court
- 730 evaluators will conduct evaluation of defendant independently

Updated Process Map
Improvement Results

County Court now returns defendant to OCJ when defendant found fit by MHFPC, which has saved:

- Defendant A: 23 days \times $395.92 = $9,106.16
- Defendant B: 8 days \times $395.92 = $3,167.36

If this practice was in effect when the defendants were first found fit, this could have potentially saved:

- Defendant A: 382 days \times $395.92 = $151,241.44
- Defendant B: 74 days \times $395.92 = $29,298.08

Control Phase

Managing Criminal Procedure
Law 730 Bed Utilization
Control Plan

- The Deputy Commissioner and the Forensic Coordinator will monitor adherence to CPL 730 Policy and Procedure.
- The Deputy Commissioner will monitor adherence to Jail Competency Maintenance Program.
- The Forensic Coordinator will track results of the implementation of CPL 730 Process on an Excel spreadsheet.
  - Non-adherence will be addressed immediately
  - Process will be reviewed for adjustments
- A Fiscal Technician will continue to monitor bed day utilization and cost.

Demonstrated Performance

Court Ordered 730 Bed Day Utilization

- 2011 was projected by multiplying first quarter cost by 4.
- Anticipate increase in $ saved with full implementation of project solutions.
Financial Impact

- County Court will issue an Order to Produce immediately upon receipt of Fitness to Proceed paperwork from MHFPC. The defendant will be transferred to Jail to await Court Competency Hearing. Using a conservative estimate of a 42 bed day reduction per defendant, an average of 11 defendants per year, at a cost of $395.92 per day, the savings computes to $182,915. This new practice alone projects to a savings that exceeds the original goal by 27%.

- Jail Competency Maintenance Program may lead to increased compliance with treatment recommendations and stabilization of symptoms for defendants. As a result, 730 evaluators may recommend capacitated more often and defendants returning from MHFPC may be maintained at the Jail throughout the court process.

Financial Impact (continued)

- 730 evaluators will use a standardized 730 report format and have increased access to information regarding the defendant. This will assist in forming their recommendation and may help identify a defendant's exaggeration of symptoms and/or malingering, leading to more recommendations of capacitated.

- Newly developed OCDMH policy and procedure will ensure timely and efficient practice through collaboration with all principles involved.
Lessons Learned

- Lean Six Sigma has brought an organized process to addressing a problem.
- We will achieve financial impact far beyond what would have been possible without applying Lean Six Sigma.
- Managing and standardizing a process improves outcomes.
- The collection and analysis of data provided a foundation for all principles that allowed for greater cooperation and willingness to change.
- Don’t accept NO for an answer.