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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clmhd.org

by
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A Forensic Manual for Directors of Community Services

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 Criminal Procedure Law (CPL) and Correction Law (CL). 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.

Changes that have occurred in NYS since the first edition of this Manual was distributed in 2012 are addressed in this edition. Specific laws that were passed (or revised) and/or processes that were implemented include:

- Outpatient Competency Restoration (CPL §730)
- Parole violation hearings (Executive Law §259)
- Placement within community hospitals for those found not competent to proceed on misdemeanor charges
- NYS SAFE Act (MHL §9.46).
- Revisions to MHL §22.09
- Legislation raising the age of criminal responsibility from 16 to 18
- Changes in AOT/Kendra's Law (MHL §960)

Other sections were revised in this second edition of the Manual, including updated and expanded appendices.

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 describe 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 MHL §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, 1/11; Appendix 1) 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 2 includes examples of these forms from Monroe and Erie 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 a 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 is 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 3 contains a brief overview of police mental health training that is mandated in NYS Police Academies and other training available to police officers, including a description of the state-wide Crisis Intervention Team (CIT) program.

MHL **§22.09** - Emergency Services for those Incapacitated by Substances

- Individuals who are judged to be incapacitated by alcohol and/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 or a "medically managed or medically supervised withdrawal, inpatient rehabilitation, or residential stabilization treatment program that has been certified" by the Office of Alcohol and Substance Abuse Services (OASAS) for such purposes. These individuals can be transported 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 incapacitation and dangerousness. Nevertheless, the presence of mental illness doesn't "disqualify" an incapacitated person from being transported on an involuntary basis pursuant to §22.09. Likewise, the presence of intoxication or impairment doesn't make someone ineligible for a §9.41 transport (or §9.45, to be discussed below).

MHL §22.09 was expanded in 2016 to allow individuals to be brought to treatment facilities certified by OASAS other than hospitals. As of this writing (August, 2017) OASAS is in the process of promulgating regulations (14 NYCRR Part 806; Emergency Services for Chemical Dependence) that will operationalize this change. [You will receive notice of the new regulations from CLMHD and it will be posted on the OASAS website.]

- Transportation – Transportation to the hospital or the treatment programs mentioned above can be done via local law enforcement or by the DCS or a designee. 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 or treatment program. 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." Erie County developed a separate 22.09 form (see Appendix 4).

- 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 or treatment facility.

- Outcome: Treatment facilities (including hospitals) are allowed to involuntarily detain an individual brought to them 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 72 hours – without the person's consent. Thus, any follow-up treatment (including referrals by a hospital and continued stay at a treatment facility) to address chemical dependency issues needs to be agreed upon by the client. There is no mechanism in the statute for ongoing involuntary chemical dependency treatment. 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. Similarly, Problem Solving Courts (including Drug, Mental Health, and Veterans Courts) often mandate chemical dependency treatment as a condition of participation.

- 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 an emergency services treatment facility. 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. Also if a DCS or designee does transport, he or she must accompany the incapacitated person to the treatment facility. Therefore, although DCS designees can initiate §22.09s, it is unclear to what extent that happens.

  When the 2016 amendment was passed as part of a professed effort to deal with the opioid problem, there was a great deal of publicity in which the amendment was made to appear as if it permitted the involuntary commitment of persons suffering from chemical dependency. In fact, the amendment does NOT authorize involuntary commitment; it simply allows a person to be taken to and held at an emergency treatment facility (as a result of the use of alcohol and/or other substances) only so long as they are either unconscious or have their judgment so impaired that they are incapable of making a rational decision with respect to their need for treatment and in no event more than 72 hours. Once that incapacitation stage passes there is no legal authority to retain that person involuntarily.

  When NYS OASAS certifies local providers to receive individuals pursuant to MHL §22.09, the DCS (and/or other LGU personnel) may opt to facilitate a dialogue between local law enforcement and those providers to clarify policies and procedures.

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; see Appendix 1) 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 or a "health officer" (appointed pursuant to Section 320 of the Public Health Law).

Also included in the list of authorized reporters are supportive and intensive case managers. However, as the overall system has shifted away from traditional case management to *care* management under the auspices of Health Home Programs, many regions in the State no longer have supportive and intensive case managers. In many instances the current care managers are the former supportive or intensive case managers. In this context, therefore, it is understandable that some localities assume that their current care managers are authorized reporters. Nevertheless, caution is advised before allowing care managers to act as authorized reporters. As of this writing (September, 2017) CLMHD Counsel has inquired with NYS OMH Counsel's Office for clarification on this issue; hopefully additional guidance will be forthcoming.

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 DCS 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 both DCSs and individuals who are appointed DCS designees are authorized to act only within the specific county in which they are 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/herself 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. It can also be helpful if a direct phone call is made to the hospital emergency department where the individual will be evaluated to provide some context about why the 9.45 was issued.

  Up-to-date 9.45 forms can be obtained from the Utica Print Shop by calling (315) 738-2960 or via email at DesignCenter@omh.ny.gov. (The on-line catalogue is no longer operational.)

- 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)." Aside from the fact that "local health officers" are not used to initiate 9.45 transports anymore, 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 §9.45 orders. Thus, an important role for the DCS is to decide who to designate as a "DCS designee." The only definition of designee in the MHL is in section 9.37 which refers to an examining physician (as that designee must actually make an evaluation). While many LGUs designate psychiatrists working in their public system as designees, there is no specific legal definition of designee for 9.45 purposes. Since a DCS is authorized to issue such orders, one good guide would be to look to the qualifications for a DCS as set forth in 14 NYCRR Part 102.6. Certainly if a designee would be qualified to be a DCS, he or she should be qualified to issue a 9.45 order. 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. Ultimately the DCS will be responsible for the decision so it is a good idea to have a formal process to check credentials of anyone applying to serve as a Designee. (As examples, Appendix 5 contains both the Monroe County Policy and the Memorandum of Understanding utilized by Ontario County.)

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 [§9.43(a)] 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. 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 crisis teams – §9.58) are often used as more effective alternatives to addressing challenges in the community.

Under the second provision [§9.43(b)] 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.

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; see Appendix 6) for these orders which jurisdictions may choose to use.

- Cost: Similar to sections of the law previously discussed (§9.41 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 with a template for that order (as contained in Appendix 6). 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 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. Unlike MHL §9.45 where the person completing the 9.45 form is not required to have evaluated the person, under §9.55 an examination is required to be conducted by the person (psychiatrist) filling out the form. Please note that Part 596.6 (a) (10) (ii) of the NYCCR forbids the use of telepsychiatry to complete 9.55s (and all other Article 9 forms).
    - 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.
    - Documentation: The state-issued form (Form OMH 474A/476A, 1/11; see Appendix 1) 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…")

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

- 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 §9.55.

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.

    - Transportation: Law enforcement and/or ambulance service transports.

    - Documentation: The state-issued form (Form OMH 474A/476A, 1/11; see Appendix 1) 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 the hospital director.

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

    - 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, present some substantial risk of harm to self or others, and for whom treatment in a hospital is judged to be appropriate. 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.)

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.

    - 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; Appendix 7).

      Within 48 hours another examination must be completed by a psychiatrist confirming the continued need for involuntary hospitalization (Form OMH 474, page 2). 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.

- Cost: Although not specifically addressed in this section of MHL, the individual admitted to the hospital under this statute is responsible for the cost.

- 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.

- 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 Services 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 for 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 pursuant to §9.27.

- Documentation: The “Application for Admission” (Form OMH 471; Appendix 8) 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 (provided a reasonable attempt has been made to find a physician designee 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. In making such transfers care must be taken to avoid violation of the Emergency Medical Treatment and Active Labor Act (EMTALA) which is a federal statute governing when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he or she is in an unstable medical condition. Its provisions apply to all patients.

  - 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; Appendix 9). 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 (by signing Form 475). Within 24 hours after admission, another physician is required to complete Form 475C documenting the need for continued inpatient treatment. Finally, an evaluation (Form 475D) by a different 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 (and the additional confirmation forms are completed, as described above) 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 designee. 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.

  You should be aware that hospitals without a 9.39 certification may seek a DCS designation for their ED physicians in order to be able to effect a transfer of a psychiatric patient presenting in their ED. As was discussed previously, MHL §9.57 allows emergency room physicians in non-9.39 facilities to transfer patients to a psychiatric facility, and thus, it is not necessary to appoint ED physicians at non-9.39 facilities as DCS designees.

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 stand-alone 'how to' manual. *Readers are strongly encouraged to read MHL §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.* NYS OMH has recently (May, 2017) posted a video on their website entitled Kendra's Law – A Fresh Look that provides an excellent overview the AOT law, including changes that were implemented in 2013 and a listing of regional NYS OMH contacts who are available for case consultation.

  Assisted Outpatient Treatment (AOT, or Kendra's Law) is intended to allow people with serious mental illness to remain in the community using court intervention to reduce dangerous behaviors that might otherwise occur if such person is not following his or her recommended treatment plan. 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, although as a practical matter this doesn't occur.

  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 receiving services in a forensic or other mental health unit of a correctional facility
      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 a demonstrated 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 one year; subsequent renewals can be for up to one year from the expiration date of the current order.

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. An AOT order is not the same as a court order to medicate over objection

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 psychiatrically hospitalized, a "§9.60 pick-up order" may be issued at the request of the physician. Per the statute, the physician requests the DCS, a DCS designee, 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 either in the place or 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. Initially, AOT programs were allowed to obtain records pursuant to MHL §33.13 (c) (12). However, the procedures for obtaining an AOT order were affected by a (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."

To obtain hospital records in the context of an AOT investigation, therefore, the AOT subject has to consent to the release of records, a court must order the release, or the records can be subpoenaed in the context of a court proceeding.

Implementation of the AOT program in most LGUs will involve close coordination with local counsel’s (county attorney or corporation counsel) offices and may require that a court proceeding be initiated in the AOT investigation so that appropriate records may either be subpoenaed or obtained by court order.

Recently there has been a significant increase in the numbers of AOT petitions that have been filed as part of the discharge plan for people coming out of state psychiatric facilities and state correctional institutions. These petitions are filed in the county in which the state hospital or prison is located and the DCS of that county is asked to appoint the state employed psychiatrist to prepare the treatment plan. After consultation with the Conference, OMH has agreed that upon filing such a petition, the DCS of the county in which the AOT subject will be residing when released will be advised of the proceeding so he/she can participate in the development of the treatment plan.

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 several times, but is still not permanent. The current version is set to expire June 30, 2022.
For additional information about AOT, readers are referred to the NYS OMH website section about AOT. It contains background information, details about program administration, guidance documents, legal forms 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 involuntary hospitalization (pursuant to §9.39), hospitalization would ensue.

- Documentation: Significant documentation is required to file an AOT petition. Guidance documents and legal forms can be found on the NYS OMH website. 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 486 (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, 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 80,000. As a practical matter, the shortage of OMH psychiatrists has meant that this provision is very seldom utilized.

- Outcome: Most counties have anecdotal reports of individuals who have been helped by AOT orders and others who have not been. The complete results of an evaluation of New York's AOT program (required by the statute) 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. If an assisted outpatient moves from one county to another while subject to an AOT order, the responsibility for supervision transfers to the appropriate director which is defined {9.60 (3)} as the DCS of the County in which the assisted outpatient resides even if the order was issued in another county.

NYS Secure Ammunition and Firearm Enforcement (SAFE) Act

The NYS SAFE Act went into effect March 16, 2013. The new law included a ban on large-capacity magazines, background checks on all ammunition purchases, tougher assault weapons ban and registration requirements, increased criminal penalties for illegal gun use, a five-year recertification for firearms licenses, changes to Kendra's Law (MHL §9.60), and the creation of MHL §9.46.

MHL **§9.46** – Reports of Substantial Risk or Threat of Harm by Mental Health Professionals

- Mental Hygiene Law §9.46 states "when a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the director of community services, or the director's designee…"

The online reporting portal asks reporters to state the "Reason you believe the person is likely to engage in conduct that would result in serious harm to self or others including any specific threats, behaviors or actions." This is interpreted by NYS OMH to mean "threats of, or attempts at, suicide/serious bodily harm to self, or homicidal/violent behavior towards others."

Please note that "mental health professionals" are defined in MHL §9.46 as physicians (including psychiatrists), psychologists, registered nurses, and licensed clinical social workers. This, of course, excludes some professional staff (e.g., LMHCs) who may be working in your County-run clinic and other local OMH-certified clinics. The procedures established by NYS OMH allow for members of a treatment team to make a report. Therefore, some agencies require non-mandated reporters who encounter an individual who meets the criteria for a SAFE Act report to consult with a supervisor (who is a physician, psychologist, nurse, or licensed clinical social worker). The supervisor can then, as part of the treatment team, make a report. The online portal is designed to ensure that the reporter is a properly credentialed professional.

It is important to note that while MHL §9.46 is part of the larger SAFE Act designed primarily to increase gun safety there is no need to link concerns about dangerousness to current or future possession of firearms. In other words, the determination of whether someone is "likely to engage in conduct that would result in serious harm to self or others" is a clinical decision that is made independent of firearm possession.

There are a variety of on-line resources available to help orient you to MHL §9.46 and that answer frequently asked questions.

As you are likely aware, there has been controversy regarding the SAFE Act since its inception and periodic discussion about repealing it. Most of the controversy has centered on the increased requirements for gun owners. Some concerns have also been expressed about the potential unintended consequence of the individuals not seeking professional help or not discussing suicidal or homicidal thoughts with a therapist for fear of being the subject of a SAFE Act report.

- Transportation: Because MHL §9.46 is about reporting individuals perceived to be dangerousness, there are no transportation issues that arise.

- Documentation: Reporters document their concerns regarding an individual's dangerousness via the online portal. The DCS or someone designated by the DCS is required to review all submissions and accept or reject them. LGU personnel cannot alter a submission, but are able to attach a note of clarification regarding the reason why the report was accepted or rejected.

- Cost: There are no additional resources available to offset the expense incurred by the LGU to review the SAFE Act reports or by providers who are mandated to submit reports.

- Outcome: After a report is accepted by LGU personnel, the demographic information about the person (name, gender, address, date of birth, social security number) is submitted to NYS Division of Criminal Justice Services (DCJS), who checks their database to see if the person has a firearm permit. If so, the "appropriate licensing official" (which in most cases is the county clerk where the person resides) is notified. The person's permit is revoked or suspended and the firearms are required to be returned to the police. If the person's weapons are not turned in, the police will be dispatched to secure them.

  If the person does not have a firearm permit, their name remains in the databases for five years. Any subsequent attempt to obtain a firearm permit will be denied.

  If a report is not approved by the LGU, the person's name is not forwarded to DCJS.

- DCS Role: The DCS (or a designee) is solely responsible for reviewing the reports submitted via the online portal and approving or rejecting them. Some LGUs, on occasion, will contact the person who submitted the report when they need additional information to make a determination about approving or rejecting a report. It is important to note that DCSs have NO role in either (1) determining if someone is entitled to a gun permit; (2) taking away guns from anyone; or (3) returning guns to anyone. If you are contacted by any person regarding their status with regard to firearms it is suggested that you should refer them to the appropriate licensing authority or suggest they consult legal counsel.

  Monroe County wrote and distributes to local providers a four page 'How to Report Guide' that includes examples of reports that were approved and those that needed additional information prior to approval. (See Appendix 10).

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 Practice Guideline was developed by the American Academy of Psychiatry and Law that provides a plethora of information including landmark court cases, challenges presented by particular clients (e.g., those diagnosed with personality disorders) and a section on ethics. Of particular relevance to readers of this Manual is the section about conducting the interview (starting on p. 31) that includes suggestions about preparing for the evaluation and specific areas to assess during the exam. There is also a section that reviews several assessment instruments (starting on p. 39) that can be used as an aid in conducting the competency evaluation, including the ECST-R used by NYS OMH personnel.

  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.

  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 if the court orders such admission). Please note, however, that given the lack of readily available State Forensic Unit beds, it is extremely unlikely that a transfer for a CPL 730 inpatient competency evaluation will occur and arrangements will likely have to be made at a 9.39 hospital with a forensic capacity or arrangements will have to be made with the Sheriff to provide appropriate security. 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 charged with a misdemeanor and found not competent.

- 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 required to be submitted. The examiner can simply sign 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. Nevertheless, many examiners submit a report to the court that summarizes their findings. This can be especially helpful in situations where someone is found competent, but the Court may need to be aware of special circumstances impacting the functioning of the defendant. For example, it may be important to inform the court that someone with a mild intellectual disability who is found competent may need some modifications to the usual court process (e.g., implementing a slower pace including allowing the attorney additional time to question the defendant to ensure adequate understanding of what is occurring in the court).

  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.)

  When a defendant is determined not to be competent and sent to a state Forensic Unit for restoration to competency, the County is charged for 50% of the per diem costs. The County is also charged 50% of the per diem costs for those hospitalized on a Forensic Unit for the purposes of completing the competency exam (although as previously mentioned, given the scarcity of available Forensic beds, it's unlikely that this will occur). The specific (full) per-diem charges (as of 2017) are as follows:

  - Kirby Forensic Psychiatric Center $ 852.43
  - Mid Hudson (Marcy): $ 852.43
    Rochester Regional Forensic Unit: $1148.43
  - Sunmount Developmental Center (OPWDD) $ 509.94
  - Valley Ridge Developmental Center (OPWDD) $ 509.94

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 in 2011. Results demonstrate an estimated decrease of over $180,000 annually. Appendix 11 contains a comprehensive PowerPoint about this project as well as the Orange County policies and procedures to effectively manage competency restoration and the associated costs.

As detailed below, charges are dismissed when individuals are found not competent on misdemeanor charges and those individuals are then referred for hospitalization or placement within the OMH or OPWDD systems. There is no county charge for that subsequent treatment.

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 34). 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 and the Court must conduct a hearing on the issue before making a decision. 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 is usually 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.

Please note that in recent years some localities have worked with NYS OMH to develop procedures so that individuals who are found not competent to proceed on misdemeanor charges are designated to local §9.39 hospitals. This prevents individuals who might need an acute, short-term admission from occupying a bed at an intermediate and longer-term stay state psychiatric unit. With the continual downsizing of state psychiatric centers some localities have prioritized admissions to state-run facilities for individuals who have already had the benefit of a short-term stay at a 9.39 facility.

OPWDD procedures are somewhat different. Individuals found not competent to proceed on a misdemeanor charge who are designated to an OPWDD 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 OPWDD 43 & OPWDD 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 felony 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.

NYS Criminal Procedure Law changed in 2012 to allow for outpatient competency restoration. Upon the consent of the District Attorney, the court can commit someone to the Commissioner for care and treatment on an outpatient basis. To date, there have been very few cases of outpatient restoration. NYS OMH has issued "Guidance for Implementation of Outpatient Competency Restoration" and an outpatient restoration manual was recently finalized and will likely be distributed to counties in the near future.

All the issues discussed above regarding competency to proceed pertain to those accused of violating their conditions of parole. As outlined in Executive Law §259-i(3)(f)(xii), if an alleged parole violator appears to be an incapacitated person, the revocation of parole will be delayed until competency evaluations are completed and reports submitted to the court. Similar to what was previously described, individuals found not competent to proceed with no felony charges pending will have the charges dismissed and be committed to the custody of the Commissioner of NYS OMH or OPWDD. Likewise, those with felony charges pending found not competent will be committed to the custody of the appropriate Commissioner to be restored to competency. Finally, for those found competent to proceed, the revocation process will proceed as usual.

- 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. Please note, however, that it remains unclear whether DCSs are entitled to any information from state psychiatric centers regarding 730 patients. A '730 workgroup' co-chaired by CLMHD Counsel and the Associate Commissioner for Forensic Services for NYS OMH will be addressing this and related issues in the fall of 2017.

  Depending on local/regional availability of 9.39 beds, the DCS may wish to consult with NYS OMH personnel about diverting individuals found not competent on misdemeanor charges to local 9.39 facilities. As discussed above, these individuals are usually admitted to state psychiatric centers. Referring these individuals to local facilities may be advantageous to the individual – who gets the benefit an acute admission (if he/she meets the criteria) and in many cases the treatment facility will be closer to their home. In addition, 'preserving' state inpatient beds for those already determined to need a longer term stay may be helpful in managing limited state resources.

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. Please note, however, that §390.30(3)(b) specifies that the report shall "contain a victim impact statement, unless it appears that such information would be of no relevance to the recommendation or court disposition…"

- 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** – Notice of Intent to Proffer Psychiatric Evidence; 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. Similarly, costs associated with an evaluation arranged by the defense would presumably be the responsibility of the defendant and/or his or her counsel (including the Public Defender's 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 Sunmount Developmental Center (in Tupper Lake) or Valley Ridge Center for Intensive Treatment (in Norwich). Initial orders of commitment are for six months and 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 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.

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 Correction 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, September, 2017). Hard copies of the Handbook (with up-to-date forms) may be obtained from the NYS OMH Division of Forensic Services at 518.549.5000.

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. In recent years there has been an increased awareness of this issue and the Stepping Up Initiative is a nationwide effort to decrease the number of individuals with mental illness in jails.

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. At the current time, due to the reduction in the numbers of state psychiatric beds and the increased numbers of CPL 730 restorations, there is a long wait for state forensic beds and many counties are choosing to use general hospital psychiatric beds if at all possible.

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 12 contains a summary flow chart (and a template for a judge's order) 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.

- 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.

- Cost: Counties (LGUs) are required to pay one-half of the per diem cost. The 2017 per diem costs are as follows:
  - Mid Hudson (Marcy): $ 852.43

- Rochester Regional Forensic Unit: $1148.43

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

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

- 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.

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.

  - Transportation: Consistent with what occurs with unsentenced individuals hospitalized under §508, local jail personnel (in most cases staff from the County Sheriff's Office) are 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.

  - Documentation: Similar to the 2PC/MHL §9.27 discussed previously, two physicians need to examine the individual and document the rationale for hospitalization (on Form 402.4). However, the individual needs to meet MHL §9.39 criteria (likelihood of serious harm to self or others), a more stringent standard than prescribed in MHL §9.27. Jail personnel are responsible for sending supporting documentation and specific forms.

- 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.

- 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.

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

SPECIAL ISSUES

Juveniles[1]

In 2017 the New York State legislature raised the age at which defendants are considered as adults, from 16 to 18. There is a phase-in period for the new law; the age of "criminal responsibility" will increase to 17 in October, 2018 and to 18 in October, 2019. Under the new law, there will be three types of offender categories; adolescent offender (AO), juvenile offender (JO) and juvenile delinquent (JD).

AOs are 16 or 17 year olds convicted of a felony. 16 or 17 years olds accused of a crime will initially be referred to a special Youth Part of the Superior Criminal Court (County or Supreme) and their cases will no longer be handled by the local city or justice courts. Judges in the Youth part will be specially trained Family Court Judges. Nonviolent offender cases (other than traffic related offenses) will automatically be removed to Family Court in most cases. The defendant will then be treated as a JD. Violent offender's cases can be removed to Family Court under certain circumstances. If the case is not removed it will be tried in the Youth Part of the superior criminal court under adult criminal procedures.

If an AO is convicted and sentenced to a definite sentence of one year or less, the youth will go to a new specialized secure juvenile detention or Office of Children and Family Services (OCFS) secure facility (judicial choice). If the sentence is one year or more and they are under 18-years-old at time of sentencing they will go to a new Department of Corrections and Community Supervision (DOCCS) AO facility. If the sentence is one year or more and the AO is 18 or older at time of sentencing, they will go to an existing DOCCS adult facility.

Juvenile Offenders (JO) are youth who are aged 13 to 15-years old at the time of being committing a serious crime (e.g. murder, manslaughter, rape, robbery 1). Their cases are tried in the Youth Part of Superior (Criminal) Court unless referred to Family Court under certain circumstances. For pretrial detention JOs are held in existing local detention facilities licensed by OCFS. Post sentence Confinement is at existing OCFS Secure Facilities.

Juvenile Delinquents (JD) are juveniles under the age of 16 at the time of committing a non JO Felony or a misdemeanor or a youth aged 16 or 17 at the time of committing a misdemeanor offense or a non-violent or violent felony offense AND was removed to Family Court by the Youth Part.

While technically a DCS does not have an official role with regard to the examination or transfer of a juvenile or adolescent, 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 or an AO whose case is transferred from the Youth

[1] Jed Wolkenbreit wrote this section.

Part is referred to Family Court. 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 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 permit 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. Although there were some updates to 42 CFR Part 2 that went into effect in 2017, the essential elements remain the same.

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. 13 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. 20 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 5 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 10, 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 is 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 11), 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 12),
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

Form OMH 474A/476A

Pursuant to NYS MHL §9.41, §9.45, §9.55 & §9.57

EMERGENCY or C.P.E.P. EMERGENCY ADMISSION**
(Sections 9.41, 9.45, 9.55 and 9.57 Mental Hygiene Law)

**Custody/Transport of a Person
Alleged To Be Mentally Ill To A Hospital Approved
To Receive Emergency or C.P.E.P. Emergency Admissions**

Person's Name (Last, First, M.I.) **"C" No.**

Sex ..... **Date of Birth** .....

Address .....

I. § 9.41 Mental Hygiene Law — Custody/Transport By Certain Peace Officers and Police Officers

I, _____ (Name), a Peace Officer/Police Officer of _____ (Department/Location), hereby acknowledge that I have taken into custody _____ (Name of Person), 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.*

A. I have removed or directed the removal of this person to _____ (Name of §9.39 Hospital/C.P.E.P.**).

OR

B. I am temporarily detaining this person at _____ (Location), a safe and comfortable place, pending examination or admission to _____ (Name of §9.39 Hospital/C.P.E.P.**). I am notifying _____ (Director of Community Services) or _____ (Health Officer) of _____ (City) or _____ (County) of this detention/removal.

Signature of Peace Officer/Police Officer	Title/Badge Number	Mo.	Day	Yr.	Hr.	Min.	☐AM ☐PM

II. § 9.45 Mental Hygiene Law — Request By A Director of Community Services or Designee

I, _____ (Name), am the Director of Community Services for _____ (City or County).

I, _____ (Name), am the designee of the Director of Community Services for _____ (City or County).

It has been reported to me that _____ (Name of 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/herself or others.*

This information has been reported to me by _____ (Name), who is:

- ☐ a licensed physician
- ☐ a licensed psychologist, registered professional nurse, or licensed social worker currently responsible for providing treatment services to the person
- ☐ a health officer
- ☐ a police officer
- ☐ a peace officer with appropriate special duties
- ☐ 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 case manager of the person***
- ☐ the intensive case manager of the person***

I hereby direct, under section 9.45 of the Mental Hygiene Law, that peace/police officers of _____ (Department/Location) take this person into custody and transport him/her to _____ (Name of §9.39 Hospital/C.P.E.P**).

OR

I hereby request, under section 9.45 of the Mental Hygiene Law, that _____ (Name of Ambulance Service) transport this person to _____ (Name of §9.39 Hospital/C.P.E.P**).

Signature of Director of Community Services or Designee	Mo.	Day	Yr.	Hr.	Min.	☐AM ☐PM

*"Likely to result in serious harm" means: (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization)*, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

**A hospital approved by the Commissioner of OMH, under MHL Section 9.39, as maintaining adequate staff and facilities for admitting patients on an emergency basis, or, a C.P.E.P. licensed by OMH to provide psychiatric emergency services to patients admitted under MHL Section 9.40.

***Includes a supportive or intensive case manager who meets the applicable qualifications established by OMH, and who has been assigned to a person by a case management program which has been approved by the Office of Mental Health for the purpose of reporting under this section (MHL§9.45).

Form OMH 474A/476A (1/11)

Custody/Transport Of A Person Alleged to be Mentally Ill To A Hospital Approved to Receive Emergency Admissions

Name (Last, First, M.I.)

III. § 9.55 Mental Hygiene Law | **Request By A Qualified Psychiatrist**

I, _____, M.D., a qualified psychiatrist*, am supervising or providing treatment for _____ at _____, a facility licensed or operated by the Office of Mental Health which does not have an inpatient psychiatric service. I have examined this person and am of the opinion that s/he appears to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm to him/herself or others.**

(Name of Person) (Name of Facility)

I hereby direct, under section 9.55 of the Mental Hygiene Law, that peace/police officers of _____. take into custody and transport this person to _____.

(Department/Location) (Name of §9.39 Hospital/ CPEP***)

–OR–

I hereby request, under section 9.55 of the Mental Hygiene Law, that_____ transport this person to _____.

(Name of Ambulance Service) (Name of §9.39 Hospital/ CPEP***)

Signature of Psychiatrist

Mo. Day Yr. Hr. Min. ☐AM ☐PM

IV. § 9.57 Mental Hygiene Law | **Request By An Emergency Room Physician**

I, _____, M.D., am an emergency room physician or provide emergency medical services at _____, a general hospital which does not have an inpatient psychiatric service.

(Name of Hospital)

–OR–

I, _____, M.D., am a physician at _____.

(Name of C.P.E.P.***)

It is my opinion, based on examination of _____, that s/he appears to have 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/herself or others.**

(Name of Person)

I hereby request that the hospital program director, or the director's designee, direct the removal of such person to a hospital approved by the Commissioner of OMH under MHL Section 9.39 or to a comprehensive psychiatric emergency program.

Signature of Physician Examiner

Mo. Day Yr. Hr. Min. ☐AM ☐PM

Based on the above request, I hereby direct under section 9.57 of the Mental Hygiene Law that peace/police officers of _____ take into custody and transport this person to _____.

(Department/Location) (Name of §9.39 Hospital/ CPEP***)

–OR–

Based on the above request, I hereby request under section 9.57 of the Mental Hygiene Law that _____ transport this person to _____.

(Name of Ambulance Service) (Name of §9.39 Hospital/ CPEP***)

Signature of Hospital Director/Designee

Mo. Day Yr. Hr. Min. ☐AM ☐PM

* A qualified psychiatrist means a physician licensed to practice medicine in NY state, who: is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board.

** "Likely to result in serious harm" means: (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization)*, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

*** A hospital approved by the Commissioner of OMH, under MHL Section 9.39, as maintaining adequate staff and facilities for admitting patients on an emergency basis, or a CPEP licensed by OMH to provide psychiatric emergency services to patients admitted under MHL section 9.40.

Appendix 2

Monroe & Erie County

9.41 Transport Forms

Monroe County Mental Hygiene Form

1. Incident Type		DOW	M	D	Y	T	4. CR#
	2. Time of Occurrence						
	3. When Reported						

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

7. Persons involved enter appropriate code for each and use narrative if required. P: patient, R: reporting person, W-1: witness 1, W-2: witness 2, PK: person with knowledge, NI: not interviewed, NO: interviewed, no information.

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

8. Where Hospitalized	9. Physical Injuries	10. Tech Work
		☐ Yes ☐ No

11. Should police be contacted before patient release? ☐ Yes ☐ No

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

Reason (i.e. Outstanding warrant(s), investigation etc.)

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

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

1

Distribution: Original - Medical Staff/ED Chart Copy 2 - Police Copy 3 - Security

REQUEST FOR EXAMINATION OF PERSON UNDER SECTION 9.41 OF THE NYS MENTAL HYGIENE LAW

☐ **To: Erie County Medical Center – CPEP**
462 Grider St., Buffalo, NY 14215

☐ **To: Lakeshore Health Care Center**
845 Routes 5 & 20, Irving, NY 14081

POLICE AGENCY/DISTRICT: _____

COMPLAINT #: _____

INCIDENT LOCATION: _____

Is responding officer CIT-trained? ____Yes

Does individual have active CIT Crisis Plan? ____Yes

DATE: _____ **TIME OF TRANSPORT:** _____

AMB CO: _____ **AMB #:** _____

Name (L, F, MI)	DOB	Age	Sex
Address (number, street, city, state, zip)			

Has this individual served in the military/reserves: ☐**Yes** ☐**No** ☐**Unknown**

Known mental health history and/or diagnosis: _____

What was reported to the police about this individual? _____

_____

_____

Name of source of information: _____ **Relationship to individual:** _____ **Phone:** _____

Any known linkages to treatment/significant others: _____

Justification for transport - Describe any known history of violence to self or others, current violent behavior, and harmful or neglectful behavior to self or others, including documentation of any plans, means, and access for suicide/harm to others: _____

_____

_____

___ Check here if a continuation page is attached

What behaviors or actions indicate that the individual might be a danger to self/others?

☐ Places self in dangerous situations
☐ Unable to care for self
☐ Threat/use of weapon to harm self/others
☐ Verbal threats
☐ Other: _____
☐ Weapon(s) present (describe): _____
☐ Talk of hurting/killing ___ self ___ others
☐ Attempting to hurt/kill ___ self ___ others
☐ Plan/means/access available
☐ Physical threats

WEAPONS CHECK PRIOR TO TRANSPORT

Searched? ☐yes ☐no

Found? ☐yes ☐no

If found, disposition: _____

_____

Check observed and/or reported behavior or actions that indicate that the individual might be a danger to self or others:

O	R	Verbal and Behavioral
☐	☐	Refusal to respond to question
☐	☐	Talking to self
☐	☐	Impaired speech (slurred, slow, illogical/incoherent, fast)
☐	☐	Reported hearing voices
☐	☐	Irrational speech/thoughts
☐	☐	Hostile/argumentative/belligerent/loud/yelling
☐	☐	Expresses ideas of inflated self-importance
☐	☐	Talks repeatedly about a single subject (death, religion, illness, government, etc.)

O	R	Appearance and Behavior
☐	☐	Paranoia/suspiciousness/feelings of persecution
☐	☐	Dress indicates lack of awareness of weather/setting
☐	☐	Confused/disoriented
☐	☐	Sad expression /crying/depression
☐	☐	Presence of feces or urine
☐	☐	Exhibits extraordinary physical strength
☐	☐	Extremely rapid heart rate/respiration
☐	☐	Poor hygiene/living environment
☐	☐	Under the influence
☐	☐	Hyperactivity/psychomotor agitation

Has a criminal charge been placed? ☐Yes ☐No If yes, charges: _____

Appearance ticked issued? ☐Yes ☐No Order of protection in force? ☐Yes ☐No

Officer's Name (please print): _____ Date: _____

HOSPITAL DISPOSITION: To be completed by Examining Physician/Emergency Room (check appropriate boxes)

☐ Patient admitted to this facility ☐ Medical admission ☐ Psychiatric admission

☐ Patient transferred to another facility ☐ Patient not admitted ☐ Patient absconded

Staff Signature: _____ Date: _____ Time: _____

Form Updated 3/24/15

Instructions

1. This form is to be prepared whenever a person is taken into custody who appears to be mentally ill, and is conducting himself/herself in a manner that he/she may harm himself/herself or other persons or property.
2. Prepare in TRIPLICATE; 1 Copy to Health Agency – 1 Copy to Ambulance or Transporting Agency – 1 Copy to Police Agency
3. 9.41 MHL is not a criminal charge. Arrest cards, disposition slips, arrest blotter entry, etc., are not required, unless a criminal charge has also been placed against the person. Complete the section on criminal charges only if a separate criminal charge has been placed against the person. If the person is not admitted to the hospital, he/she shall be returned to headquarters and the appropriate criminal charge placed against him/her.
4. Officer shall be required to provide their name on the form, in the appropriate section.
5. This form shall not be utilized for 22.09 transports.
6. 9.41 transports can only go to ECMC and Lakeshore Health Care Center; the VA is not authorized to accept 9.41 transports. Individuals wishing to be admitted to the VA can make this request known at ECMC and Lakeshore Health Care Center, and a transfer may be an option.
7. CIT-trained officers should indicate such in the top left section of the form, including whether the individual being transported has an active CIT Crisis Plan.

Section 9.41 of the New York State Mental Hygiene Law

Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers

Any peace officer, when acting pursuant to his or her special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Such officer may direct the removal of such person or remove him or her to any hospital specified in subdivision (a) of section 9.39 or any comprehensive psychiatric emergency program specified in subdivision (a) of section 9.40, or, pending his or her examination or admission to any such hospital or program, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action. * NB Effective until July 1, 2012 * § 9.41 Emergency admissions for immediate observation, care, and treatment; powers of certain peace officers and police officers. Any peace officer, when acting pursuant to his special duties, or police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department may take into custody any person who appears to be mentally ill and is conducting himself in a manner which is likely to result in serious harm to himself or others. "Likelihood to result in serious harm" shall mean (1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. Such officer may direct the removal of such person or remove him to any hospital specified in subdivision (a) of section 9.39 or, pending his examination or admission to any such hospital, temporarily detain any such person in another safe and comfortable place, in which event, such officer shall immediately notify the director of community services or, if there be none, the health officer of the city or county of such action. * NB Effective July 1, 2012

Appendix 3

Police Mental Health Training in NYS

Brief Review of Police Mental Health Training Available in NYS

The NYS Office of Mental Health, in collaboration with the NYS Division of Criminal Justice Services, is responsible for providing and/or preparing others to provide training to help law enforcement officers assess and intervene with persons suffering from emotional distress. There are several training initiatives, described below.

The first is a three-day Police Mental Health Instructor Development Course that prepares police and mental health instructors to teach the two-day Police Mental Health Recruit Training delivered in the police academies across the state. Taught by "master trainers" (both mental health clinicians and police officers) the Train-the-Trainer program reviews the curriculum content and focuses on training strategies to prepare police and mental health clinicians to co-instruct the two-day recruit curriculum. The recruit course 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 document their actions. Please note that as of this writing (September, 2017), NYS Office of Mental Health Division of Forensic Services personnel have completed extensive revisions to the recruit curriculum and plan to expand it to three days.

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 program is available and is delivered by NYS OMH personnel and consultants. "Effectively Responding to Emotional Crisis" is a one-day in-service program designed as a review of what is covered in the recruit training as well as providing a more in depth look at communication, de-escalation, suicide and officer wellness.

NYS OMH also offers a Train-the-Trainer program for the Suicide Prevention in County Jails and Police Lock-ups. The course provides instructor training in understanding and assessing suicide risk, mental illness and suicide, substance abuse and suicide, suicide prevention screening guidelines and suicide prevention after cell assignment. The Suicide Prevention course is designed to be co-presented by a law enforcement instructor and a county or other local mental health instructor in a team teaching format

"How Being Trauma Informed Improves Criminal Justice Outcomes" is a 6-hour training on trauma and its impact on individuals in the criminal justice system. It emphasizes how being trauma informed can lead to better outcomes. NYS OMH offers this course for community-based criminal justice system professionals, including law enforcement, community corrections (probation, parole, and pre-trial services), court personnel, as well as human service providers that serve adult justice-involved populations.

Additional information about the Recruit Train-the-Trainer course, the one-day in-service training, the Suicide Prevention Train-the-Trainer course, and the 6-hour

trauma training is available from the NYS OMH Division of Forensic Services (forensictraining@omh.ny.gov).

The last component of Police Mental Health Training in NYS involves the development of Crisis Intervention Team (CIT) programs. CIT programs work to transform crisis response systems so that police are not the first responders to individuals suffering emotional crises in the community. CIT programs also prepare law enforcement officers so that when they are the first responders they have the knowledge, skills and support to de-escalate situations and divert individuals from the criminal and juvenile justice systems, when it's appropriate to do so. As part of CIT program development, experienced police officers volunteer to receive additional week-long training in mental health-related issues. Among the goals of CIT programs are to reduce the number of arrests of individuals with mental illness, refer them to treatment facilities or other support services, and eliminate adverse incidents between law enforcement and those with mental illness. CIT programs involve ongoing collaboration and partnerships between and among law enforcement, the mental health system, and consumer and advocacy groups. Although there have been no controlled studies to date, program evaluations have shown good outcomes (i.e., lower arrest rates, increased referrals for treatment, and decreased use of force).

Rochester developed the first CIT program in NYS in 2004. Between 2004 and 2014 several other localities across the state created similar programs. In 2014 the NYS Senate provided resources to NYS OMH to develop a state-wide CIT program, and has funded the program on a yearly basis since then. In addition to the week-long advanced training, the program also involves an initial assessment of the crisis response system (based on the Sequential Intercept Model) in the localities targeted for CIT program development. New York City has its own CIT program.

Additional information about the state-wide CIT program can be obtained from the NYS OMH Division of Forensic Services (forensictraining@omh.ny.gov) and from OMH's lead consultant for the CIT initiative (Don Kamin, Ph.D.; dkamin@nyscit.org)

Appendix 4

Erie County 22.09 Transport Form

REQUEST FOR EXAMINATION OF PERSON UNDER SECTION 22.09 OF THE NYS MENTAL HYGIENE LAW

POLICE AGENCY/DISTRICT: _____

COMPLAINT #: _____

INCIDENT LOCATION: _____

DATE: _____ **TIME OF TRANSPORT:** _____

AMB CO: _____ **AMB #:** _____

WEAPONS CHECK PRIOR TO TRANSPORT
Searched? ☐yes ☐no
Found? ☐yes ☐no
If found, disposition: _____

HOSPITAL TRANSPORTED TO (see list on reverse): _____

Name (L, F, MI)	DOB	Age	Sex
Address (number, street, city, state, zip)			

Has this individual served in the military/reserves: ☐**Yes** ☐**No** ☐**Unknown**

Describe incident that resulted in police involvement: _____

Suspected/known use of: ❑ **alcohol** ❑ **opiates (cocaine; heroin; pain meds)** ❑ **sedatives (valium; xanax)** ❑ **other/unknown:** _____

Any known mental health history and/or diagnosis: _____

Reporter of information: ❑ **self** ❑ **other:** _____

What behaviors or actions indicate that the individual is incapacitated as a result of alcohol or substance use?

☐ Placing self in dangerous situation(s)
☐ Unable to care for self
☐ Other: _____
☐ Talk of hurting/killing _____ self _____others
☐ Attempt to hurt/kill _____ self _____others

Additional information supporting the need to enact 22.09, if any: _____

_____Check here if continuation page is attached

Check observed and/or reported behaviors or actions that indicate that the individual is incapacitated:

Signs of intoxication

☐ Smell of alcohol
☐ Slurred speech
☐ Staggering gait
☐ Incontinence
☐ Flushed face
☐ Red eyes or pinpoint pupils
☐ Vomiting
☐ Positive BAC (level, if known)_____
☐ Lack of inhibitions and/or judgment
☐ Complains of itching or scratching
☐ Drowsy
☐ Sedated
☐ Drooling
☐ Erratic/irrational behavior and/or speech

Signs of withdrawal

☐ Clammy skin
☐ Irritability
☐ Enlarged pupils
☐ Sweating
☐ Seizures
☐ Confusion
☐ Hallucinations
☐ Depression
☐ Anxiety
☐ Restless
☐ Dilated pupils
☐ Gooseflesh
☐ Yawning/fatigue
☐ Cramps
☐ Hand/body tremors
☐ Muscle aches
☐ Memory impairment

Has a criminal charge been placed? ☐Yes ☐No If yes, charges: _____
Appearance ticked issued? ☐Yes ☐No Order of protection in force? ☐Yes ☐No
Officer's Name (please print):_____ Date: _____

HOSPITAL DISPOSITION: To be completed by Examining Physician/Emergency Room (check appropriate box)
☐ Patient admitted to this facility ☐ Medical Admission ☐ Psychiatric Admission
☐ Patient transferred to another facility ☐ Patient not admitted ☐ Patient absconded
Staff Signature: _____ Date: _____ Time: _____

Form Updated 3/24/2015

Instructions

1. This form is to be prepared whenever a person is taken into custody that appears to be intoxicated or impaired (see below for definitions) and requires involuntary transport to an emergency room.
2. Prepare in TRIPLICATE; 1 Copy to Health Agency – 1 Copy to Ambulance or Transporting Agency – 1 Copy to Police Agency
3. 22.09 transports are considered medical transports and can be transported to any medical emergency room listed below:

Bertrand Chaffee Hospital 224 East Main St Springville, NY 14141 716-592-2871	**Kenmore Mercy Hospital** 2950 Elmwood Avenue Kenmore, NY 14217 716-447-6100	**Sisters of Charity Hospital** 2157 Main Street Buffalo, NY 14214 716-862-1000
Buffalo General Medical Center (BGH) 100 High Street Buffalo, NY 14203 716-859-5600	**Mercy Hospital of Buffalo** 565 Abbott Road Buffalo, NY 14220 716-828-7000	**Sisters of Charity Hospital - St Joseph Campus** 2605 Harlem Road Cheektowaga, NY 14225 716-891-2400
Erie County Medical Center (ECMC) 462 Grider Street Buffalo, NY 14215 716-898-3000	**Millard Fillmore Suburban Hospital** 1540 Maple Road Amherst, NY 14221 716-568-3600	**Women And Children's Hospital Of Buffalo** 219 Bryant Street Buffalo, NY 14222 716-878-7000
Lakeshore Health Care Center (TLC) 845 Routes 5&20 Irving, NY 14081 716-951-7000		**Mercy Ambulatory Care Center (MACC)** 3669 Southwestern Boulevard Orchard Park, NY 14127 716- 662-0500

Section 22.09 of the New York State Mental Hygiene Law

Emergency services for persons intoxicated, impaired, or incapacitated by alcohol and/or substances

1. "Intoxicated or impaired person" means a person whose mental or physical functioning is substantially impaired as a result of the presence of alcohol and/or substances in his or her body. 2. "Incapacitated" means that a person, as a result of the use of alcohol and/or substances, is unconscious or has his or her judgment otherwise so impaired that he or she is incapable of realizing and making a rational decision with respect to his or her need for treatment. 3. "Likelihood to result in harm" or "likely to result in harm" means (i) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (ii) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm. 4. "Hospital" means a general hospital as defined in article twenty-eight of the public health law. (b) An intoxicated or impaired person may come voluntarily for emergency treatment to a chemical dependence program or treatment facility authorized by the commissioner to give such emergency treatment. A person who appears to be intoxicated or impaired and who consents to the proffered help may be assisted by any peace officer acting pursuant to his or her special duties, police officer, or by a designee of the director of community services to return to his or her home, to a chemical dependence program or treatment facility, or to any other facility authorized by the commissioner to give emergency treatment. In such cases, the peace officer, police officer, or designee of the director of community services shall accompany the intoxicated or impaired person in a manner which is reasonably designed to assure his or her safety, as set forth in regulations promulgated in accordance with subdivision (f) of this section. (c) A person who appears to be incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or to others may be taken by a peace officer acting pursuant to his or her special duties, or a police officer who is a member of the state police or of an authorized police department or force or of a sheriff's department or by the director of community services or a person duly designated by him or her to a general hospital or to any other place authorized by the commissioner in regulations promulgated in accordance with subdivision (f) of this section to give emergency treatment, for immediate observation, care, and emergency treatment. Every reasonable effort shall be made to protect the health and safety of such person, including but not limited to the requirement that the peace officer, police officer, or director of community services or his or her designee shall accompany the apparently incapacitated person in a manner which is reasonably designed to assure his or her safety, as set forth in regulations promulgated in accordance with subdivision (f) of this section. (d) A person who comes voluntarily or is brought without his or her objection to any such facility or program in accordance with subdivision (c) of this section shall be given emergency care and treatment at such place if found suitable therefor by authorized personnel, or referred to another suitable facility or treatment program for care and treatment, or sent to his or her home. (e) A person who is brought with his or her objection to any facility or treatment program in accordance with subdivision (c) of this section shall be examined as soon as possible by an examining physician. If such examining physician determines that such person is incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or others, he or she may be retained for emergency treatment. If the examining physician determines that such person is not incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or others, he or she must be released. Notwithstanding any other law, in no event may such person be retained against his or her objection beyond whichever is the shorter of the following: (i) the time that he or she is 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 or (ii) a period longer than forty-eight hours. 1. Every reasonable effort must be made to obtain the person's consent to give prompt notification of a person's retention in a facility or program pursuant to this section to his or her closest relative or friend, and, if requested by such person, to his or her attorney and personal physician, in accordance with federal confidentiality regulations. 2. A person may not be retained pursuant to this section beyond a period of forty-eight hours without his or her consent. Persons suitable therefor may be voluntarily admitted to a chemical dependence program or facility pursuant to this article. (f) The commissioner shall promulgate regulations, after consulting with representatives of appropriate law enforcement and chemical dependence providers of services, establishing procedures for taking intoxicated or impaired persons and persons apparently incapacitated by alcohol and/or substances to their residences or to appropriate public or private facilities for emergency treatment and for minimizing the role of the police in obtaining treatment of such persons.

Appendix 5

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.
    1. Consideration will be given to appoint non-psychiatrist physician designees at hospitals where there is not 24 hour, on-site psychiatrist coverage. To be considered under this exception, non-psychiatrist designees must agree to consult with the on-call psychiatrist prior to initiating a 9.37 transfer.

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. (Non-psychiatrist 9.37 designees shall not be 9.45 designees). 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 shall also be eligible to be 9.45 designees. Such individuals shall be currently licensed psychologists, licensed 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 and the Chief of Priority Services.

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.

B. To ensure that individuals appointed as DCS designees understand the pertinent sections of Mental Hygiene Law and how those are operationalized in Monroe County, prospective DCS designees must attend in-service instruction on this topic provided by Monroe County Office of Mental Health staff Kimberly Butler, Chief, Clinical and Forensic Services. Case by case exceptions may be made (i.e., long standing designees who leave one agency and are being appointed at the request of another agency.)

C. 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.

D. 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. It is the responsibility of the Monroe County Office of Mental Health to provide 911 with accurate up-to-date lists of DCS designees. Law enforcement are informed that they can call 911 for verification of an individual's DCS designee status.

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:
Diane L Johnston, LCSW-R
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
- □ NYS License
- □ NYS Registration
- □ Evidence of a negative State Central Register Database check by NYS Office of Children and Families if appropriate 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)] **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) **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.

_____ _____

Diane L Johnston, LCSW-R 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

Appendix 6

Form OMH 465
Civil Order for Removal to Hospital
Pursuant to MHL §9.43

Civil Order For Removal to Hospital

(*Pursuant to Section 9.43 of the Mental Hygiene Law*)

State of New York

_____ Court, _____
(City, County, or Village)

In the matter of hospitalization Pursuant to section 9.43 of the Mental Hygiene Law of _____ An alleged mentally ill person

_____ being brought before this court and it appearing to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm to himself or others and the Director of _____, a hospital specified in Section 9.39 of the Mental Hygiene Law having agreed to receive such person, for determination whether such person should be retained.

NOW, THEREFORE, it is

ORDERED that pursuant to the provisions of Section 9.43 of the Mental Hygiene Law, the said _____ be removed to _____ for a determination by the Director of such hospital whether such person should be retained therein pursuant to the provisions of Section 9.39 of such law.

Dated_____19_____ _____
(SIGNATURE)

_____
(PRINT NAME TO BE SIGNED)

Justice or Judge, _____
(COURT)

Appendix 7

Form OMH 474
Emergency Admission
Pursuant to MHL §9.39

EMERGENCY ADMISSION
Section 9.39 Mental Hygiene Law

Patient's Name (Last, First, M.I.) "C" No.

.....

Sex.....Date of Birth.....

Facility Name Unit/Ward No.

I. General Provisions for Emergency Admission

A. In order for a person to be admitted to a hospital according to Section 9.39 of the Mental Hygiene Law, all the following requirements must be met:
1. The hospital must be approved by the Commissioner of Mental Health to receive and retain patients according to this Section;
2. The person must be alleged to have a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. "Likelihood to result in serious harm" means:
   - a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself ("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization), or
   - a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.
3. A staff physician of the admitting hospital must examine the person and find that the person meets the standard for admission under this Section. The physician then completes this Form, OMH 474, Emergency Admission.

B. A person who is alleged or appears to be mentally ill may be taken into custody, transported, or removed to a hospital approved to accept emergency admissions, according to the following sections of the Mental Hygiene Law:
- Section 9.41- Powers of Certain Peace Officers and Police Officers, Form OMH 474A/476A, I
- Section 9.43- Powers of Courts- Form OMH 465, Civil Order for Removal to Hospital
- Section 9.45- Powers of Directors of Community Services, Form OMH 474A/476A, II
- Section 9.55- Powers of Qualified Psychiatrists, Form OMH 474A/476A, III
- Section 9.57- Powers of Emergency Room Physicians, Form OMH 474A/476A, IV

C. On admission, the person will be given a written notice of status and rights as a patient admitted according to MHL Section 9.39. This notice will also be given to the Mental Hygiene Legal Service and up to three other persons designated by the person admitted.

If a person admitted according to this Section is to be retained in the hospital for more than 48 hours, another physician, who is a member of the psychiatric staff of the hospital, must examine the person and confirm the admitting physician's findings by completing page 2 of this form (OMH 474).

Within 15 days of admission, if it is determined that the person is not in need of involuntary care and treatment, s/he shall be discharged unless s/he is suitable and agrees to remain as a voluntary or informal patient. If the person is in need of continued inpatient care and treatment, and is not suitable or will not agree to remain as a voluntary or informal patient, s/he may be retained beyond 15 days only by completion of an application and two medical examinations as required for admission according to MHL Section 9.27- Involuntary Admission on Medical Certification.

II. Record of Admission

Name

A. The above-named person was brought to this hospital by:

Title/Badge No. (as appropriate) Address Phone

Relationship to Person Address of Person Time of arrival at hospital:

Month	Day	Year	Hour	Minute	☐ A.M. ☐ P.M.

B. Circumstances which led to the person being brought to this hospital:

(If applicable) Person was taken into custody, transported, or removed to this hospital in accordance with MHL Section _____.

C. I HAVE EXAMINED THE ABOVE-NAMED PERSON PRIOR TO ADMISSION AND FIND THERE IS REASONABLE CAUSE TO BELIEVE THAT THE PERSON HAS A MENTAL ILLNESS FOR WHICH IMMEDIATE OBSERVATION, CARE AND TREATMENT IN A MENTAL HOSPITAL IS APPROPRIATE AND WHICH IS LIKELY TO RESULT IN SERIOUS HARM TO HIMSELF OR HERSELF OR OTHERS.

Admitting Physician's Signature:

Month	Day	Year	Hour	Minute	☐ A.M. ☐ P.M.

EMERGENCY ADMISSION Section 9.39 Mental Hygiene Law	Patient's Name (Last, First, M.I.)	"C" No.

III. Examination to Confirm Need for Extension of Emergency Admission Beyond 48 Hours

A. Pertinent and Significant Factors in Patient's Medical and Psychiatric History:

B. Physical Condition (including any special test reports):

C. Mental Condition: The conduct of the patient (including statements made to me by others) has been:

D. The patient shows the following psychiatric signs and symptoms:

E. Does the patient show a tendency to cause serious harm to him/herself? ☐ Yes ☐ No to others? ☐ Yes ☐ No

If yes, explain: _____

F. Mental diagnosis (If determined): _____

F. Staff Psychiatrist's Confirmation:

I have personally observed and examined _____ on:
(Patient's Name)

								☐ A.M.
Month		Day		Year		Hour	Minute	☐ P.M.

Based on such examination and the case history, I hereby confirm that there is reasonable cause to believe that the patient has a mental illness for with immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. The facts stated and information contained herein are true to the best of my knowledge and belief.

I am on the psychiatric staff of _____ Hospital. _____
(Signature)

Appendix 8

Form OMH 471
Application for Involuntary Admission on Medical Certification
Pursuant to MHL §9.27

APPLICATION FOR INVOLUNTARY ADMISSION ON MEDICAL CERTIFICATION

Sections 9.27 Mental Hygiene Law

Note: The Examining Physician must consider alternative forms of care and treatment that might be adequate to provide for the person's needs without requiring involuntary hospitalization.

I. GENERAL PROVISIONS FOR INVOLUNTARY ADMISSION ON MEDICAL CERTIFICATION

A. Standard for Admission

A person alleged to be mentally ill and in need of involuntary care and treatment may be admitted to a hospital providing inpatient services for the mentally ill, upon the certificates of two examining physicians accompanied by an application for admission for such a person.

- "In need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment.
- The person in need of involuntary care and treatment must, as a result of his or her mental illness, pose a "substantial threat of harm to self or others" (see definition in Part B on page 2 of this form).

B. Application

The application must be made within 10 days prior to admission by:

- any person with whom the person alleged to be mentally ill resides;
- the father or mother, spouse, brother or sister, or the child of any such person or the nearest available relative;
- the committee of such person;
- an officer of any public or well recognized charitable institution or agency or home, including but not limited to the superintendent of a correctional facility, as such term is defined in section 2(4)(a) of the Correction Law, in whose institution the person alleged to be mentally ill resides;
- the director of community services or social services official, as defined in the Social Services Law, of the city or county in which any such person may be;
- the director of the hospital or of a general hospital, as defined in article twenty-eight of the Public Health Law, in which the patient is hospitalized;
- the director or person in charge of a facility providing care to alcoholics or substance abusers or substance dependent persons;
- the director of the division for youth (now the Office of Children and Family Services), acting in accordance with the provisions of section five hundred nine of the Executive Law;
- subject to the terms of any court order or any instrument executed pursuant to section 384-a of the Social Services Law, a social services official or authorized agency which has, pursuant to the Social Services Law, care and custody or guardianship and custody of a child over the age of sixteen;
- subject to the terms of any court order, a person or entity having custody of a child pursuant to an order issued pursuant to section seven hundred fifty-six or one thousand fifty-five of the Family Court Act; or
- a qualified psychiatrist* who is either supervising the treatment of or treating such person for a mental illness in a facility licensed or operated by the Office of Mental Health (*means a physician licensed to practice medicine in NY State, who is a diplomate of the American Board of Psychiatry and Neurology or is eligible to be certified by that Board, or who is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that Board).

C. Certification by Two Examining Physicians

The application must be supported and accompanied by two Certificates of Examining Physician (Form 471A). The examinations may be conducted jointly, but each examining physician must execute a separate certificate. If the examining physician knows that the person under examination has received prior treatment, s/he must, if possible, consult with the physician or clinician furnishing such prior treatment.

The required examinations must be made within 10 days prior to the date of the patient's admission to the hospital.

A person is disqualified from acting as an examining physician if:

- he or she is not licensed to practice medicine in New York State;
- he or she is a relative of the person applying for admission, or of the person alleged to be in need of hospitalization;
- he or she is a manager, trustee, visitor, proprietor, officer, director, or stockholder of the hospital in which the patient is hospitalized or to which it is proposed to admit such person, or has any financial interest in such hospital other than receipt of fees, privileges or compensation for treating or examining patients in such hospital; or
- he or she is on the staff of a proprietary hospital to which it is proposed to admit such a person.

D. Hospital Evaluation, Admission and Retention

A physician on the psychiatric staff of the hospital, other than the original examining physicians, must examine the person alleged to be mentally ill forthwith and confirm the need for involuntary care and treatment prior to admission. Subsequent to admission, if no request for a court hearing is made, the director may retain the patient for up to 60 days without taking other action.

If the hospital director determines that the condition of the patient requires hospitalization beyond 60 days:

- The patient may remain as a voluntary or informal patient if willing and suitable for such status.
- If the patient is unwilling or not suitable to remain as a voluntary or informal patient, the director must apply, before the end of the 60 day period, for a court order authorizing continued retention of the patient. The director must also inform the patient, the Mental Hygiene Legal Service, and others who received the original notice of the patient's commitment, that said director is applying for a court order, to give them the opportunity to request a hearing before the court, if they so desire.

Form OMH 471 (MH) (9/11)

State of New York
OFFICE OF MENTAL HEALTH

APPLICATION FOR INVOLUNTARY ADMISSION ON MEDICAL CERTIFICATION

Sections 9.27 Mental Hygiene Law

II. GENERAL INFORMATION

A. Mental Hygiene Legal Service

The Mental Hygiene Legal Service is an agency of the New York State Supreme Court which provides protective legal services, advice and assistance, including representation, to all patients admitted to psychiatric facilities. Patients are entitled to be informed of their rights regarding hospitalization and treatment, and have a right to a court hearing, to be represented by a lawyer, and to seek independent medical opinion.

There is a Mental Hygiene Legal Service office in many psychiatric hospitals. Where there is no office at the hospital, a representative of the

Service visits periodically and frequently. Any patient or anyone on his or her behalf may see or communicate with a representative of the Service by telephoning or writing directly to the office of the Service or by requesting someone on the staff of the patient's ward to make such arrangements for him or her. The Mental Hygiene Legal Service for the hospital may be reached at: _____.

B. Reimbursement

The patient is legally responsible for the cost of care. Additionally responsible are the patient's spouse and in some cases the parents of a patient under the age of 21. Also legally responsible are the committee, guardian, or trustee of a trust fund established for support of the patient, or any fiduciary or payee of funds for the patient.

Charges may be waived or reduced when there is inability to pay. Any person who applies for a waiver or reduction of charges must cooperate in a financial investigation to determine ability to pay.

PART A — Application for Admission

I hereby apply for the admission of _____
(Name of person)

to _____, a hospital providing services for persons with mental illness.
(Name of Hospital)

My reasons for applying for admission of this person are as follows:

_____

_____

_____

_____

_____

_____

_____

_____

Under penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

Signature of Applicant	Relationship/Title

Address	Date		
	MO.	DAY	YEAR

PART B — Psychiatrist's Confirmation of Need for Involuntary Care and Treatment in a Hospital

I HAVE EXAMINED THE ABOVE-NAMED PERSON PRIOR TO ADMISSION* AND CONFIRM:

- that the person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and
- that as a result of his or her mental illness, the person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with noncompliance with mental health treatment programs)*.

Signature of Examining Staff Psychiatrist	Date			Time	
					A.M.
	MO.	DAY	YEAR		P.M.

**NOTE: Part B must be completed for new admissions and for conversions of already-admitted patients to §9.27 Involuntary Status.*

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.)

……

Sex……Date of Birth…….....

Address……

CERTIFICATION

I, _____, herby certify that:
(Name of Examining Physician)

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person

   on: | | | | (Mo. / Day / Yr.) at _____
   (place where examined)

3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for persons with mental illnesses ("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment); and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others ("substantial threat of harm" may encompass: (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care; or (ii) the person's history of dangerous conduct associated with noncompliance with mental health treatment programs).
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

Signature	Print Name Signed	Title					
Address	Phone Number	Date			Time		
		Mo.	Day	Yr.	Hr.	Min.	AM PM

	Person's Name (Last, First, M.I.)

REQUEST BY AN EXAMINING PHYSICIAN TO TAKE INTO CUSTODY/TRANSPORT A MENTALLY ILL PERSON

(SECTION 9.27 (i) MENTAL HYGIENE LAW)

PART A REQUEST FOR CUSTODY AND TRANSPORTATION OF A MENTALLY ILL PERSON BY A PEACE OFFICER OR A POLICE OFFICER

Pursuant to the authority granted me under Section 9.27 (i) of the Mental Hygiene Law,

I, _____ M.D., hereby request _____
(Name of Examining Physician) (Name & Badge # of Peace/Police Officer)

to take _____ into custody and transport this person to
(Name of Person)

_____.
(Name and Address of Hospital)

I have examined this person and have certified that he/she is mentally ill and in need of involuntary hospitalization. This person has also been certified as mentally ill by another examining physician and an application for admission has been completed.

_____ M.D. _____ _____
(Signature) (Time) (Date)

_____
(Location/Address)

PART B REQUEST FOR TRANSPORTATION OF A MENTALLY ILL PERSON BY AN AMBULANCE SERVICE

I, _____ M.D., hereby request _____
(Name of Examining Physician) (Name of Ambulance Service)

is hereby authorized under Section 9.27 (i) Mental Hygiene Law to transport _____
(Name of Person)

to: _____.
(Name and Address of Hospital)

I have examined this person and have certified that he/she is mentally ill and in need of involuntary hospitalization. This person has also been certified as mentally ill by another examining physician and an application for admission has been completed.

_____ M.D. _____ _____
(Signature) (Time) (Date)

_____
(Location/Address)

Appendix 9

Form OMH 475
Application for Involuntary Admission on Certificate of DCS or Designee
Pursuant to MHL §9.37

APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE

Section 9.37 Mental Hygiene law

Patient's Name (Last, First, M.I.) "C" No:

Sex: . . . . . Date of Birth: . . . . . .

Address: . . . . . .

I. GENERAL PROVISIONS FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DCS OR DESIGNEE

A. Standard for Admission

If, in the opinion of a Director of Community Services (DCS) or an examining physician duly designated by him or her, a person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to the person or others, the person may be admitted to a hospital providing such care and treatment, upon the certificate of the DCS or designee accompanied by an application for admission of the person.

"Likely to result in serious harm" means:

- A substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization)*, or
- A substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

B. Application and Certification

The application made by the DCS or his or her designee must be supported and accompanied by a Certificate of Examination by Director of Community Services or Designee (Form 475A), except under the circumstances described in the next paragraph.

In counties with a population of less than 200,000, a DCS who is not a physician but who is a licensed psychologist or a licensed clinical social worker may apply for admission of a person without a medical examination by a designated examining physician, if:

- A hospital approved by the State Commissioner of Mental Health to admit patients pursuant to Section 9.39 of the Mental Hygiene law is not located within 30 miles of the person;
- The DCS has made a reasonable effort to locate a designated examining physician but such a designee is not immediately available; and
- The DCS's application is supported by a Certificate of Observation by Director of Community Services (Form 475B) which states that after personal observation of the person, the DCS reasonably believes that the person may have a mental illness which is likely to result in serious harm to himself or herself or others and that inpatient care and treatment in a hospital may be appropriate.

Examining physicians designated by the DCS must be approved by the State Commissioner of Mental Health. A person is disqualified from acting as an examining physician if:

- he or she is not licensed to practice medicine in New York State,
- he or she is a relative of the person certified to be in need of hospitalization,
- he or she is a manager, trustee, visitor, proprietor, officer, director, or stockholder of the hospital to which it is proposed to admit such person, or has any financial interest in such hospital other than receipt of fees, privileges or compensation for treating or examining patients in such hospital, or
- he or she is on the staff of a proprietary hospital to which it is proposed to admit such person.

C. Custody and Transport

After completing the application, the DCS or his or her designee is empowered to take into custody, detain, transport, and provide temporary care for the person. Upon request of the DCS or designee, it shall be the legal duty of peace officers, acting pursuant to their special duties, or police officers to take into custody and transport the person as directed by such DCS or designee. Alternatively, the DCS or designee may request that an ambulance service provide transportation.

D. Hospital Evaluation

If a person is to be admitted on the basis of Form 475A (Certificate of Examination by Director of Community Services or Designee), the need for immediate hospitalization must be confirmed by a staff physician of the hospital prior to admission.

If a person is to be admitted on the basis of Form 475B (Certificate of Observation by Director of Community Services), a staff physician must certify upon examination of the person prior to admission that the person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to the person or others. The need for hospitalization must then be confirmed by another staff physician within twenty-four hours after admission, using Form 475C (Examination within 24 hours).

Following admission, the patient may be involuntarily retained beyond 72 hours (excluding Sundays and holidays) only if he or she is examined by another physician who is a staff psychiatrist, and Form 475D (Examination within 72 Hours) is completed.

If no request for a court hearing is made, the hospital director may retain the patient for up to 60 days from the date of admission without taking other action.

If the hospital director determines that the condition of the patient requires hospitalization beyond 60 days:

- The patient may remain as a voluntary or informal patient if he or she is willing and suitable for such status.
- If the patient is unwilling or not suitable to remain as a voluntary or informal patient, the director must apply, before the end of the 60 day period, for a court order authorizing continued retention of the patient. The director must also inform the patient, the Mental Hygiene Legal Service, and others who received the original notice of the patient's commitment, that said director is applying for a court order, to give them the opportunity to request a hearing before the court, if they so desire.

State of New York
OFFICE OF MENTAL HEALTH

APPLICATION FOR INVOLUNTARY ADMISSION ON CERTIFICATE OF A DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE
Section 9.37 Mental Hygiene law

Patient's Name (Last, First, M.I.) | "C" No:

II. GENERAL INFORMATION

A. Mental Hygiene Legal Service

The Mental Hygiene Legal Service is an agency of the New York State Supreme Court which provides protective legal services, advice and assistance, including representation, to all patients admitted to psychiatric facilities. Patients are entitled to be informed of their rights regarding hospitalization and treatment, and have a right to a court hearing, to be presented by a lawyer, and to seek independent medical opinion.

There is a Mental Hygiene Legal Service office in many psychiatric hospitals. Where there is no office at the hospital, a representative of the Service visits periodically and frequently. Any patient or anyone in his or her behalf may see or communicate with a representative of the Service by telephoning or writing directly to the office of the Service or by requesting someone on the staff of the patient's ward to make such arrangements for him or her. The Mental Health Hygiene Legal Service representative for this hospital may be reached at: _____

B. Reimbursement

The patient is legally responsible for payment for the cost of care. Additionally responsible are the patient's spouse and in some cases parents of a patient under the age of 21. Also legally responsible are the committee, guardian, or trustee of a trust fund established for the support of the patient, or any fiduciary or payee of funds for patient.

Charges may be waived or reduced when there is inability to pay. Any person who applies for a waiver or reduction of charges must cooperate in a financial investigation to determine ability to pay.

STATE AND FEDERAL LAWS prohibit discrimination based on race, creed, color, national origin, age, sex or disability.

PART A — APPLICATION FOR ADMISSION

I hereby request that _____ be admitted to _____.
(Name of person) (Name of Hospital)

This request is made due to behavior and/or specific acts described below:

_____

_____

_____

Under the penalty of perjury, I attest that the information supplied on this application is true to the best of my knowledge and belief.

Signature of Director of Community Services or Designee	Official Title

Address	DATE MONTH	DAY	YEAR

PART B — CUSTODY TRANSPORT OF THE PERSON ALLEGED TO BE MENTALLY ILL *(OPTIONAL)*

I hereby direct, under the Mental Hygiene Law, that the peace/police officers of _____ take the above-named person into custody and transport him/her to the above-named hospital.
(Department/Location)

-or-

I hereby request, under the Mental Hygiene Law, that _____ transport the above-named person to the above-named hospital.
(Name of Ambulance Service)

Physician's Signature	DATE MONTH	DAY	YEAR	TIME HOUR	MINUTE	☐ A.M. ☐ P.M.

PART C — PHYSICIAN'S CONFIRMATION FOR IMMEDIATE HOSPITALIZATION

I am a physician on the staff of the above-named hospital providing services for persons with mental illness. I hereby confirm the following *(Check one)*:

☐ That the above named person has been referred upon the application and certification of a **Director of Community Services or Designee** who is a **physician**, and that the above-named person is in need of immediate hospitalization.

☐ That the above named person has been referred upon the application and certification of a **Director of Community Services or Designee** who is a **non-physician**, and that I have examined the above-named person and determined that he or she has a mental illness for which immediate inpatient care and treatment in a mental hospital is appropriate and which is likely to result in serious harm to himself or herself or others.

Physician's Signature	DATE MONTH	DAY	YEAR	TIME HOUR	MINUTE	☐ A.M. ☐ P.M.

Form OMH 475A (6/10)

State of New York
OFFICE OF MENTAL HEALTH

CERTIFICATE OF EXAMINATION BY DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE Section 9.37 Mental Hygiene Law

Person's Name (Last, First, M.I.) "C" No.

.....

Sex.....Date of Birth.....

Address.....

I,_____, hereby certify that:

a. On the _____ day of _____, 20____, I personally examined _____, who was located at _____, and in my opinion this person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate.

b. It is my opinion that this person's mental illness is likely to result in serious harm to himself or herself or others. By "likely to result in serious harm," I mean:

(Check appropriate statements)

❑ a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization);*

and/or

❑ a substantial risk of physical harm to other persons, as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

c. The behavior or specific act(s) of this person on which I base my opinion is (are) described in Part A of Form 475, "Application for Involuntary Admission on Certificate of a Director of Community Services or Designee".

d. (Check appropriate statement below and complete)

❑ I am a physician licensed to practice medicine in New York State and am the Director of Community Services for the persons with mental disabilities for (City) (County) _____.

or

❑ I am a physician licensed to practice medicine in New York State and have been designated by the Director of Community Services for persons with mental disabilities for (City) (County) of _____ _____ to conduct examinations on his or her behalf.

e. I certify that this person's hospital admission is medically necessary.

Signature of Director of Community Services or Designee	Title	Date

Address	Telephone Number

Form OMH 475B (2/09)

State of New York
OFFICE OF MENTAL HEALTH

CERTIFICATE OF OBSERVATION BY DIRECTOR OF COMMUNITY SERVICES (NON-PHYSICIAN) Section 9.37 Mental Hygiene Law

Person's Name (Last, First, M.I.) "C" No.

.....

Sex.....Date of Birth.....

Address.....

I,_____, hereby certify that:

a. On the _____ day of _____, 20____, I personally observed _____,

_____ who was located at _____,
and in my opinion inpatient care and treatment of this person in a hospital may be appropriate.

b. It is my opinion that this person may have a mental illness which is likely to result in serious harm to himself or herself or others. By "likely to result in serious harm," I mean:

(Check appropriate statements)

❑ a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization);*

and/or

❑ a substantial risk of physical harm to the persons, as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

c. The behavior or specific act(s) of this person on which I base my opinion is (are) described in Part A of Form 475, "Application for Involuntary Admission on Certificate of a Director of Community Services or Designee".

d. I am the Director of Community Services for the mentally disabled for the County of _____

_____, which has a population of less than 200,000 persons.

e. I am:

❑ a licensed psychologist.

or

❑ a certified social worker.

f. I believe that a hospital approved by the State Commissioner of Mental Health to admit patients pursuant to Section 9.39 of the Mental Hygiene Law is not located within 30 miles of this person.

g. I have made a reasonable effort to locate a designated examining physician but one is not immediately available.

(Describe the measures taken to locate such a physician and the reason why one is not immediately available for example: unsuccessful attempt to contact by telephone or visit; unavailable due to illness, distance, medical duties, etc. if more space is needed, add additional page.)

_____

_____

_____

h. I believe that this person's hospital admission may be appropriate.

_____ _____ _____
Signature of Director of Community Services | title | Date

_____ _____
Address | Telephone Number

Form OMH 475C (1-08)

State of New York
Office of Mental Health

EXAMINATION WITHIN 24 HOURS

(To Confirm the Need for Hospitalization of a Patient Admitted on a Certificate of Observation by a Director of Community Service)

Section 9.37 (c) Mental Hygiene Law

Patient's Name (Last, First, M.I.) "C" No.

……..

Sex……Date of Birth……

Facility Name……..Unit/Ward No……

INSTRUCTIONS:
To be completed by a staff physician, other than the admitting physician, within 24 hours after admission.

1. Pertinent and Significant Factors in Patient's Medical and Psychiatric History:

2. Physical Condition (including any special test reports):

3. Mental Condition: The conduct of the patient (including statements made to me by others) has been:

4. The patient shows the following psychiatric signs and symptoms:

5. Does the patient show a tendency to harm him/herself? Yes ☐ No ☐ to harm others? Yes ☐ No ☐

If yes, explain ——————————

6. Mental Diagnosis (if determined): ——————————

I, _____, do certify as follows:
(Print Name Clearly)

a. I have with care and diligence personally examined the above named patient on:

Mo		Day		Yr.	

and as a result of such examination, find and hereby certify:

- that the patient is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and
- that as a result of his or her mental illness, the patient poses a substantial threat of harm to self or others ("substantial threat of harm" may encompass (i) the patient's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the patient's history of dangerous conduct associated with noncompliance with mental health treatment programs).

b. I have formed this opinion based on the case history and my examination of the patient as detailed above.

c. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

Physician's Signature

Mo		Day		Yr.	

Form OMH 475D (6/10)

State of New York
Office of Mental Health

EXAMINATION WITHIN 72 HOURS

(To Retain a Patient Admitted on a Certificate of Examination or a Certificate of Observation by a Director of Community Services)

Patient's Name (Last, First, M.I.) "C" No.

……

Sex……Date of Birth……..…

Facility Name……...Unit/Ward No.

INSTRUCTIONS:
To be completed within 72 hours after admission, excluding Sundays and holidays, by a physician who is a member of the psychiatric staff, other than the admitting physician or the physician who completed Form 475C, Examination Within 24 hours (if applicable).

1. Pertinent and Significant Factors in Patient's Medical and Psychiatric History:

2. Physical Condition (including any special test reports):

3. Mental Condition: The conduct of the patient (including statements made to me by others) has been:

4. The patient shows the following psychiatric signs and symptoms:

5. Does the patient show a tendency to harm him/herself? Yes ☐ No ☐ to harm others? Yes ☐ No ☐

If yes, explain _____

6. Mental Diagnosis (if determined): _____

I, _____, do certify as follows:
(Print Name Clearly)

a. I have with care and diligence personally examined the above named patient on:

Mo		Day		Yr.	

and as a result of such examination, find and hereby certify:

- that the patient is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill; and
- that as a result of his or her mental illness, the patient poses a substantial threat of harm to self or others ("substantial threat of harm" may encompass (i) the patient's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the patient's history of dangerous conduct associated with noncompliance with mental health treatment programs).

b. I have formed this opinion based on the case history and my examination of the patient as detailed above.

c. I hereby certify that the facts stated and information contained in this certificate are true to the best of my knowledge and belief.

Staff Psychiatrist's Signature

Mo		Day		Yr.	

Appendix 10

Monroe County SAFE Act ‘How to Report’ Guide
Pursuant to MHL §9.46

The NY SAFE Act (MHL §9.46):
A 'How to Report' Guide for Monroe County

This brief guide provides information about how Monroe County Office of Mental Health personnel evaluates SAFE Act reports. By sharing this information it is our hope to decrease the number of times that we need to contact reporters for clarification and make the reporting process more efficient for all involved. For comprehensive background information on the SAFE Act, a list of 'Frequently Asked Questions,' and access to the NYS Office of Mental Health reporting portal, please consult the NYS OMH SAFE Act webpage: http://www.omh.ny.gov/omhweb/safe_act/ .

Briefly, Mental Hygiene Law 9.46 states "when a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the director of community services, or the director's designee…" The online reporting portal asks reporters to state the "Reason you believe the person is likely to engage in conduct that would result in serious harm to self or others including any specific threats, behaviors or actions." **This is interpreted by State OMH to have the same meaning as "likelihood of serious harm" which is defined in current law as "threats of, or attempts at, suicide/serious bodily harm to self, or homicidal/violent behavior towards others."** There is a prompt that directs reporters to "Enter any specific threats, behaviors or actions here."

Pursuant to the NY SAFE Act, it is the responsibility of the County Office of Mental Health to review and evaluate each SAFE Act report made regarding individuals residing in the County (even if they are seen at an out-of-county hospital). In most circumstances we need to act upon reports within one business day.

Upon review, County staff has a few options:

1) We can approve the report and that person's name is forwarded to the NYS Division of Criminal Justice (DCJS) database.
2) We can reject the report and the name will not be included in the DCJS database.
3) We can contact the reporter and ask for additional information so that we can make a determination about whether to approve or reject the report.

The vast majority of the reports we have received to date have been approved. Many others, however, have required us to contact the reporter for clarification because there was not a clear articulation of the reason the reporter believed the person was "likely to engage in conduct that would result in serious harm to self or others." We do not require a thorough summary of the clinical assessment (and in fact, would prefer not to receive lengthy reports). We do, however, need a clear articulation of the reason the person was judged to be potentially dangerous. **Although reports that have been submitted cannot be modified, we do have the ability to attach a note explaining additional details obtained during our review.**

The remainder of this Guide highlights key areas that, based on our experience since the initiation of the SAFE Act (in March, 2013) would benefit from some clarification.

***IMPORTANT DISCLAIMER*: This guide is only about the process of *how* our Office decides to approve, reject or seek additional information from reporting clinicians. No guidance is offered about *when* licensed professionals covered under the NY SAFE Act should report. For 'When to Report' guidance, please consult your agency's internal policies and procedures.**

POSSESSION OF FIREARMS

Although Mental Hygiene Law 9.46 is part of the Secure Ammunition and Firearms Enforcement (SAFE) Act, there is no need to link concerns about dangerousness to the current or future possession of firearms. **We approve (or reject) reports based on the description of the concerns regarding dangerousness, independent of potential possession of firearms**. In other words, unless there's sufficient description of concerns about dangerousness that is independent of firearm possession, we'd either reject the report or ask for clarification.

Examples of reports that require clarification:

- "Pt had psychotic episode and had gun confiscated by police. Pt still apparently has active gun permit; has not been fully compliant with meds and is continuing with delusional thoughts and paranoia."
- "Individual is very depressed and known to own a gun."

Examples of reports that would be approved:

- "Currently not taking medications and very paranoid. Has threatened to shoot his father and has access to firearms."
- "Patient is very depressed and expresses plan to kill self. Does not report access to firearms."
- "Client expressed desire to die and plan to jump off bridge. Family removed firearms from residence."

SUICIDAL IDEATION

We assume that inpatient admissions occurring in the context of suicidal ideation are warranted based on potential dangerousness. However, **we will not approve reports that do not clearly articulate dangerousness**. We require that there is some brief statement that details the extent and/or risk of action – due to plans or intent.

Examples of reports that require clarification:

- "Patient presents with suicidal ideation. Admitted on 9.39 status."
- "Patient presented with a report of worsening depression, suicidal ideation, comorbid drug abuse, all in the context of significant psychosocial stressors."

Examples of reports that would be approved:

- "She has suicidal ideation with plan to overdose on pills."
- "Patient has history of significant suicide attempt and is currently expressing suicidal ideation with intent."
- "Currently expressing suicidal ideation (saying she plans to drive her car off a bridge) and will not contract for safety."

MHL 9.45 / MHAs

Reporting that the person's condition required that a 9.45 be initiated is not a sufficient description of dangerousness for us to approve the report. While we understand that the 9.45 would not have been initiated unless the person was judged to be potentially dangerousness, **we still need to have a brief statement that details the reason that the person is thought to be dangerous**.

Examples of reports that require clarification:

- "Patient 9.45'd, transported to hospital and was admitted. Submitting per our policy re: 9.45s."
- "Patient was MHA'd from residence after becoming agitated with staff and other patients there."
- "Presented at hospital as MHA with suicidal ideation."

Examples of reports that would be approved:

- "Pt 9.45'd after stating a plan to cut his throat."
- "Patient presents depressed, suicidal with plan/intent to stab himself. MHA was initiated and is now being hospitalized for safety and stabilization."
- "Client reports having command hallucinations to hurt his mother. 9.45'd to hospital where he is being admitted."

PSYCHOSIS

In order for us to approve reports submitted about individuals who are psychotic **there needs to be a clear articulation about the concerns regarding dangerousness**. Similar to the discussion about suicidal ideation above, we understand that those individuals who have been admitted to an inpatient unit secondary to psychosis were likely to be judged to be at risk of 'dangerousness.' Nevertheless, we need a brief statement about that dangerousness.

Examples of reports that require clarification:

- "Pt presented with increased depression, delusions, religious preoccupation and passive suicidal ideation."
- "Patient psychotic and making threatening comments towards others."
- "Patient is psychotic and unable to care for self."
- "Patient decompensated, tangential, paranoid and non-compliant with medications."

Examples of reports that would be approved:

- "Delusional; he thinks people from school are assassins and are going to kill him. He has contemplated acting on paranoid delusions to protect himself; has mentioned killing others before they kill him."
- "…claiming to be God and shooting at neighbor with BB gun."
- "Psychotic; jumped in front of car and was hit; paranoid."
- "Patient psychotic. Recently violent towards family members (assaulted father) and threatening towards ED staff."
- "Has command hallucinations to drink poison. Currently very violent and disorganized."

INABILITY TO CARE FOR SELF

Consistent with all other examples in this Guide, reports of individuals citing an inability to care for themselves **must be accompanied by a clear description of why such conduct would result in serious harm to themselves**.

Examples of reports that require clarification:

- "Depressed, isolated, hearing voices, minimally responsive upon interview."
- "Pt. is seen today for follow up appointment after inpatient treatment for catatonia. Pt. presents not at her baseline. She is barely speaking, has some thought blocking and latency to speech. She admitted she is not taking her medications."

Examples of reports that would be approved:

- "The patient is at risk of self-harm due to concerns of beginning of potential catatonia (based on recent history) and inability to care for herself, as evidenced by a lack of any self-care (she has not eaten for several days and not taken her cardiac medication).
- "Patient presents as grossly psychotic. Threatening staff and states he would hit anyone who touched him. At medical risk because of paranoia of water being poisoned, and therefore not drinking. Significant weight loss in past month due to inability to care for self."

HISTORY OF DANGEROUS ACTS

A person's history is certainly a significant variable in judging potential dangerousness. However, a history of dangerous acts in and of itself is not sufficient for us to approve a report. **There needs to be some specific, current concern that the person may be dangerous** (which can be supported by the history, if relevant).

Examples of reports that require clarification:

- "Arrested and charged with Arson 4 months ago. Has a long history of impulsive behavior and frequent arrest and incarceration – at times secondary to acting on his paranoid delusions."
- "Patient has a history of physical violence. Patient remains labile and aggressive toward others."
- "Patient has a history of domestic violence and fights within homeless shelter."
- "Admitted to inpatient 3 months ago due to an overdose and auditory hallucinations commanding him to hurt himself. Given the same circumstance in patient's environment, he could revert back to same behavior."

Examples of reports that would be approved:

- "Patient is decompensating and stopped taking medications 6 weeks ago. Has history of violence against wife when symptomatic. Currently very paranoid and making threats to kill others, consistent with past cycles of aggression."
- "Drug use; currently threatening suicide; history of violence towards self and others."
- "Brought in by ambulance after roommate found her unresponsive in bed with 2 empty bottles of Seroquel nearby. Patient is unable to articulate that she overdosed but has a history of overdose in 2012."

REPORTS BASED ON SECOND HAND INFORMATION

As noted earlier in this document, MHL 9.46 reports must be based on "reasonable professional judgment" that the individual "is likely to engage in conduct that would result in serious harm to self or others." Occasionally, a mental health professional may be contacted by a third party (relative, spouse, friend, etc.) with safety concerns about an individual and may consequently feel responsible for submitting a SAFE Act report. In order for such a report to be approved, **the submitting professional needs to establish the validity of the risk in the context of recent clinical contacts and/or his/her own clinical judgment**.

Reports requiring clarification:

- "Wife called this morning and reported feeling unsafe due to husband's paranoia and threats that he would kill her."
- "Client's mother called to report that she is concerned for his safety due to recent suicidal comments and impulsive behaviors."

Examples of reports that would be approved:

- "Wife called this morning and reported feeling unsafe due to husband's paranoia and threats that he would kill her. I overheard husband in background making threats to harm her. I called 911 and completed a 9.45."
- "Client's brother called and reports that client is in crisis and threatening to kill himself. Records indicate client recently stopped medications against advice of tx team. Has a history of similar cycles in past resulting in multiple serious suicide attempts. Missed clinic appointment this morning. Completed 9.45."

INTERFACE WITH CHEMICAL DEPENDENCY SERVICES

MHL 9.46 reports must be made consistent with the federal confidentiality rules (42 CFR Part 2) which prevent disclosure of information that would identify an individual as receiving substance use disorder services without consent. **Substance use may be indicated in a report, but participation in substance use disorder services may not**. This will result in the report being rejected (since it cannot be modified) and may require a new submission that omits mention of participation in substance use services.

Examples of reports that would be rejected:

- "Patient was threating to kill himself by jumping from a bridge and would not contract for safety with either his CD treatment counselor or this writer."
- "Suicide attempt during recent relapse on drugs after being discharged from inpatient rehab."

Examples of reports that would be approved:

- "Patient with cocaine dependence and depression admitted after a suicide attempt, he remains suicidal with a plan to overdose."
- "Patient with alcohol abuse and depression found hanging by his roommate in a suicide attempt."

Additional questions should be directed to: **Kimberly Butler, LCSW, M.S.; Chief Clinical & Forensic Services**
Monroe County Office of Mental Health, 585-753-6335, 585-753-5530
kbutler@monroecounty.gov

Initial version by D. Kamin & D. Putney, October, 2013. Revisions by R. Corry & D. Kamin, February, 2015.
Contact information updated February, 2017.

Appendix 11

Orange County
Lean Six Sigma Project to Reduce 730 Bed Utilization
&
Department of Mental Health CPL 730 Policy and Procedure
&
Jail Clinic CPL 730 Policy and Procedure

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
- OCDMH – Orange County Department of Mental Health
- OCJ – Orange County Jail
- PRN – as needed

Define Phase

Managing Criminal Procedure Law 730 Bed Utilization

3

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.

4

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.

5

Team Members

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

6

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.

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SIPOC

Suppliers	Inputs	Process	Outputs	Customers
County Court Judges Jail Clinicians Evaluators State Forensic Hospital Personnel	CPL 730 Evaluations Clinical Intervention Medication Compliance Clinical / Psychiatric History	Evaluating Defendants Restoring Defendants to Competency	Competent Defendants	Judges District Attorney's Office Defense Attorneys Defendants

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Measure Phase

Managing Criminal Procedure Law 730 Bed Utilization

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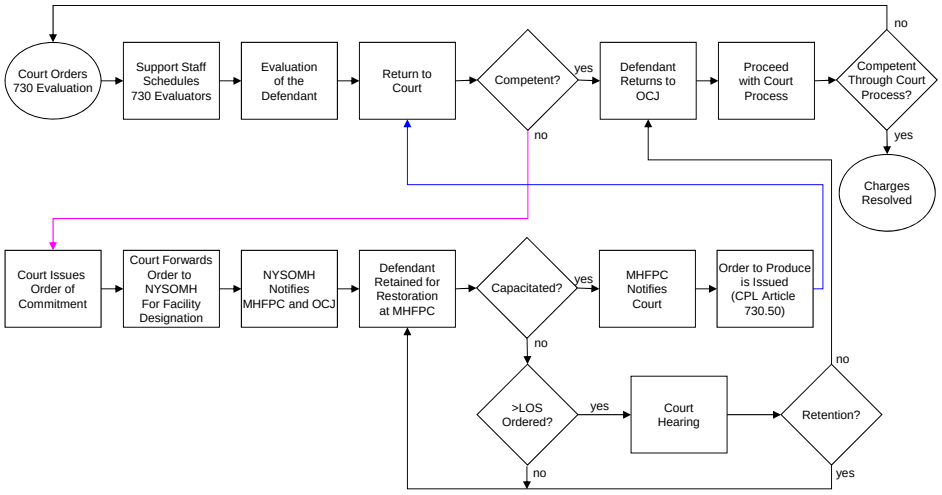
Operational Definition

- 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

10

730 Process Map



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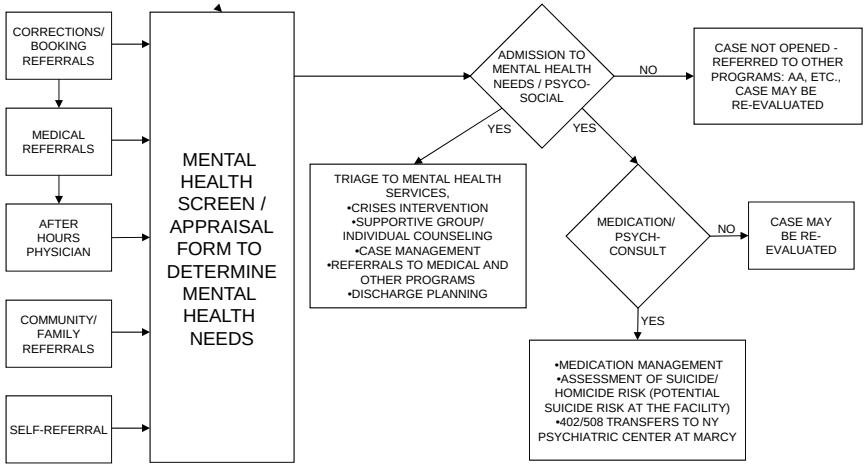
OCJ At Risk Individuals Flow



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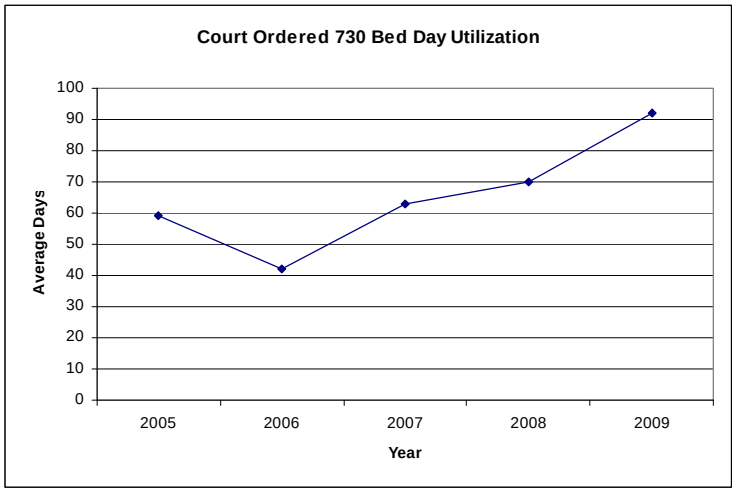
Baseline Data



-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

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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

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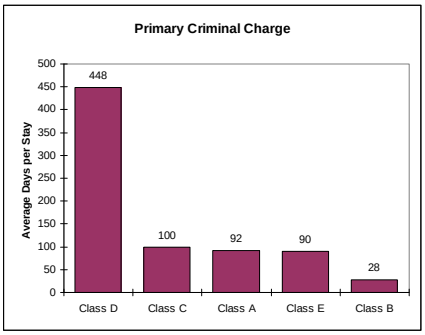
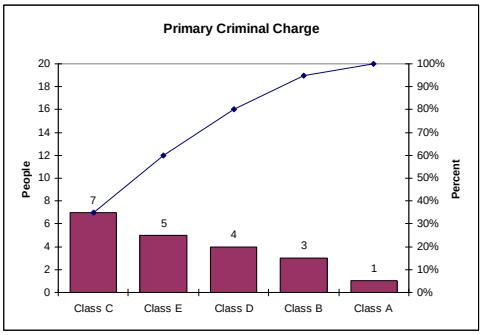
Pareto Chart

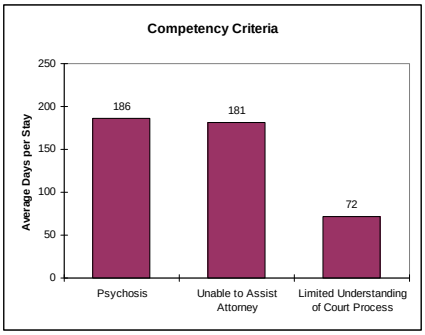


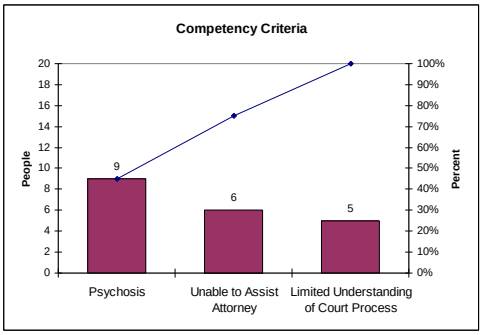


Class D, a lower level felony, has the longest average length of stay, accounting for 4 of the 20 defendants.

15

Pareto Chart





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.

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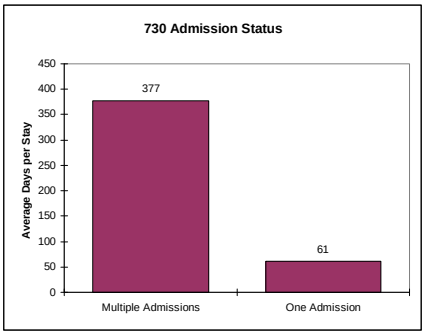
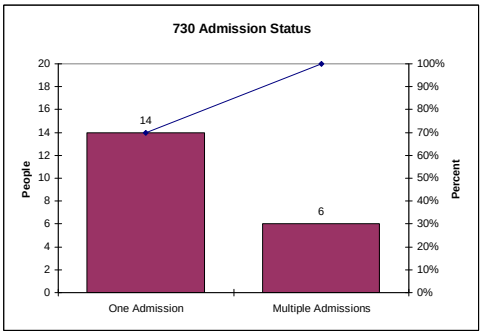
Pareto Chart

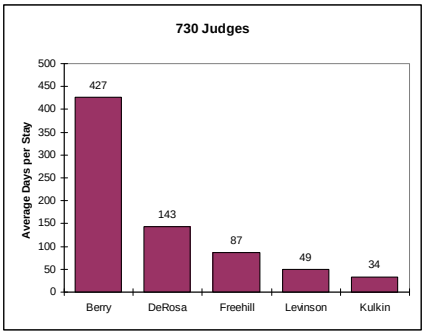


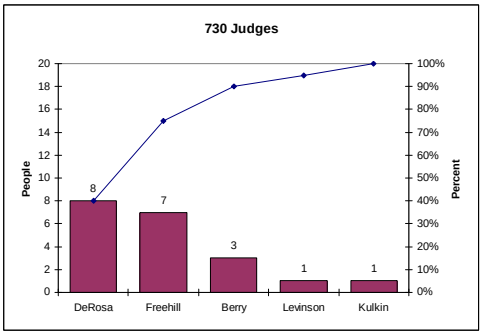


Multiple admissions accounted for the longest average length of stay and pose the greatest difficulty in restoring and maintaining competency.

17

Pareto Chart





Judge Berry has the longest average length of stay, accounting for 3 of the 20 defendants.

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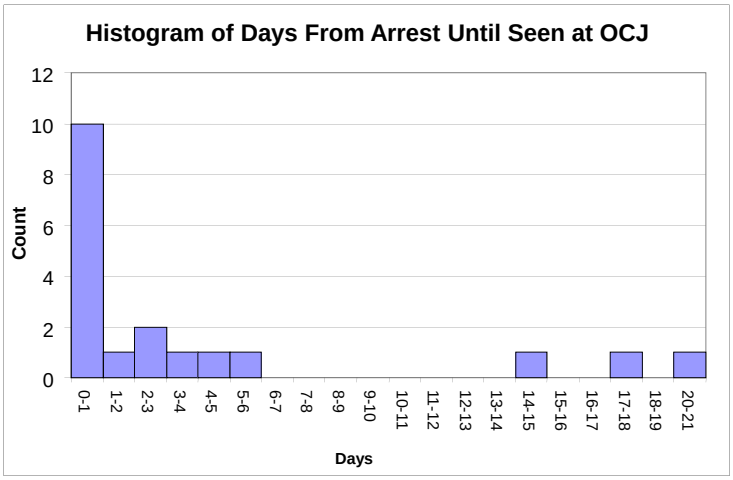
Histogram



-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.

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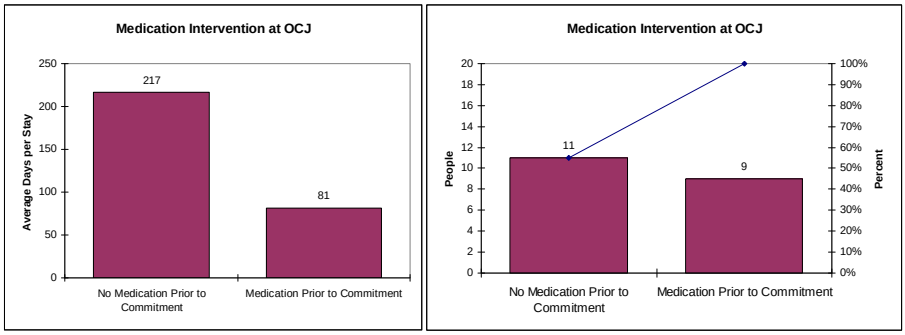
Pareto Chart



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

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Analyze Phase

Managing Criminal Procedure Law 730 Bed Utilization

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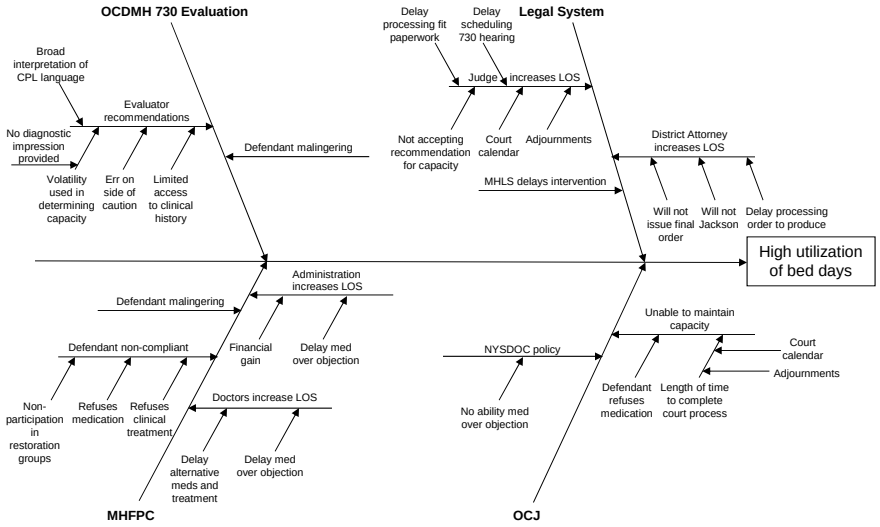
Cause and Effect Diagram



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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

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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

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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

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Improve Phase

Managing Criminal Procedure Law 730 Bed Utilization

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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

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Solution Evaluation

		Potential Improvement Impact		
		High	**Medium**	**Low**
Ability of Team to Make and Control Changes	Control	- OCDMH monitoring / managing 730 process - Educate all parties 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
	Influence		- 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
	No Control			- Developing a Mental Health Court

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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

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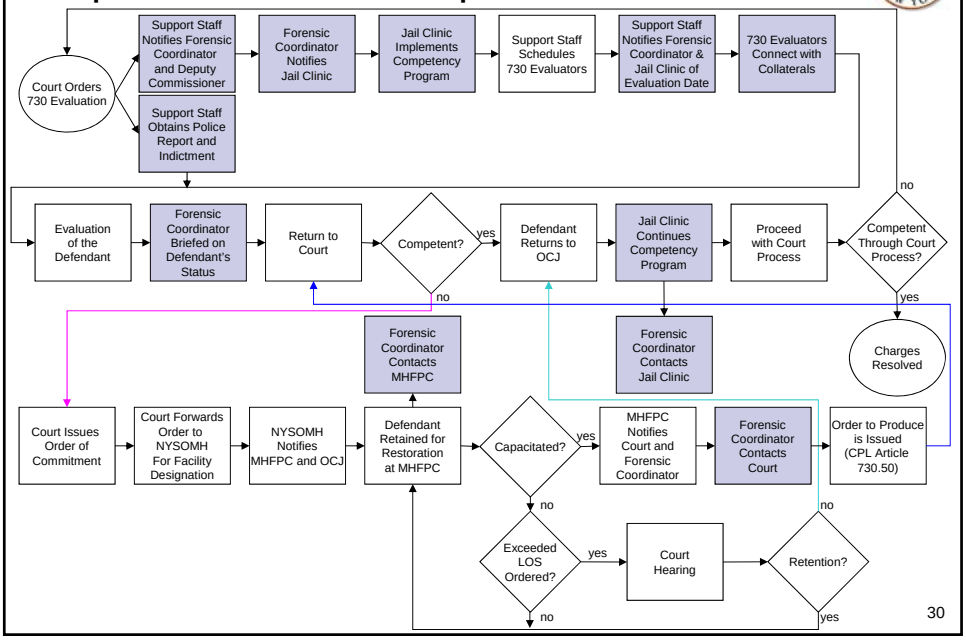
Updated Process Map



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Improvement Results

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

- Defendant A: 23 days X $395.92 = $9,106.16
- Defendant B: 8 days X $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 X $395.92 = $151,241.44
- Defendant B: 74 days X $395.92 = $ 29,298.08

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Control Phase

Managing Criminal Procedure Law 730 Bed Utilization

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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.

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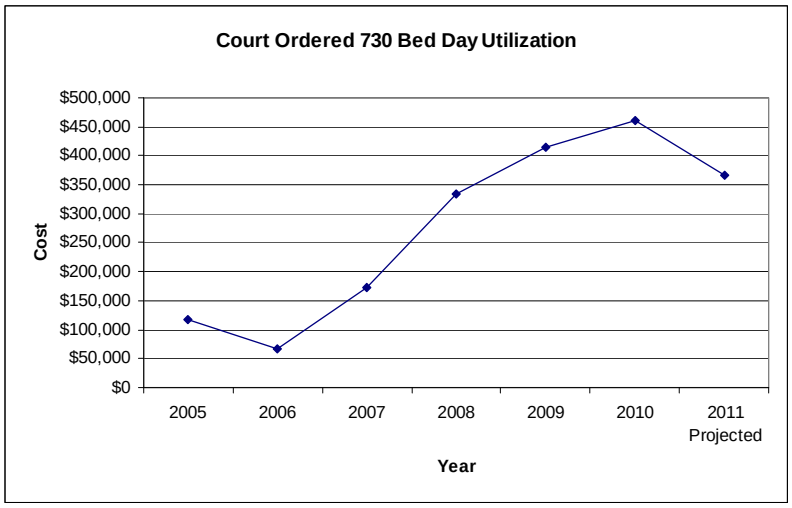
Demonstrated Performance



-2011 was projected by multiplying first quarter cost by 4.

- Anticipate increase in $ saved with full implementation of project solutions.

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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.

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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.

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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.

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Orange County Department of Mental Health CPL 730 Policy and Procedure

The Orange County Department of Mental Health (OCDMH) Forensic Coordinator will provide oversight, intervention, and support throughout the Criminal Procedure Law (CPL) 730 process for all defendants involved in Orange County Criminal Court.

- When OCDMH receives a court order for a CPL 730 for defendants involved in County Court and those who begin in a lower court, but are indicted with a felony, the support staff will notify the Forensic Coordinator, Senior Secretary / Administrative Assistant, Commissioner, and the Jail Clinic by email. Place a copy of the order in the Forensic Coordinator's mailbox and fax the order to the Jail Clinic.

- The Senior Secretary / Administrative Assistant will begin entering data into the CPL 730 Six Sigma Excel Spreadsheet. The Excel Spreadsheet will serve as part of the control plan to be completed throughout the CPL 730 process by the Senior Secretary / Administrative Assistant with data input from the Fiscal Technician.

- The support staff will ensure that a copy of the police report, the indictment, and contact information for the defense attorney are included with the order. If they are not included the support staff will contact the court and request this documentation/information, which must be available prior to the examination.

- The Forensic Coordinator will make contact with the Jail Clinic, confirming receipt of the current order, request information regarding clinician assigned, notify the Senior Secretary / Administrative Assistant, and write the name of the assigned clinician in the defendant's CPL 730 file.

- The Jail Clinic will implement the Competency Maintenance Program as outlined in the procedure and provide the Forensic Coordinator with the date the Competency Maintenance Program was implemented. The Forensic Coordinator and Clinical Team at the Jail Clinic will continue to communicate about the defendant's course of treatment, especially as it relates to compliance vs. non-compliance with Jail Clinic services and the date medication is taken.

- The support staff will schedule the 730 evaluators to conduct predominantly independent examinations of the defendant approximately two weeks prior to the court return date. The support staff will notify the Forensic Coordinator, Senior Secretary / Administrative Assistant, and the assigned clinician (as noted in the file) of the evaluation date(s).

- The support staff will mail a letter to the defendant and a copy to the defense attorney, informing them of the scheduled examination date.

- Jail Clinical Team will e-mail or fax the Jail Clinic Mental Health Appraisal form and the Jail Competency Status form to the support staff within five days of the scheduled examination date.

- Support Staff will create a file for the 730 Evaluators that will include copies of the following:

    - Court Order
    - Police Report
    - Indictment
    - Jail Clinic Mental Health Appraisal form
    - Jail Competency Status form

- The 730 evaluators will conduct predominantly independent examinations of the defendant and provide their written recommendation using a standardized format. The support staff will provide the Forensic Coordinator with the reports for review prior to sending to the Court.

- If the 730 evaluators need additional evaluation time with the defendant in order to complete their examination, he/she may obtain consent to allow for additional payment from OCDMH by contacting the Forensic Coordinator or the Commissioner.

- If the defendant is found competent at the Competency Court Hearing, the defendant will return to Orange County Jail (OCJ) and the Jail Clinical Team will continue with Competency Maintenance Program.

- If the defendant is found incompetent at the Competency Court Hearing, Court will issue an Order of Observation or an Order of Commitment. The defendant will return to OCJ to await a hospital designation from the New York State Office of Mental Health Bureau of Forensics. Jail Clinical Team will continue Competency Maintenance Program. The defendant will be transported to Mid-Hudson Forensic Psychiatric Center (MHFPC). The Jail Clinical Team will notify the Forensic Coordinator of the defendant's transfer date. Forensic Coordinator will notify Senior Secretary / Administrative Assistant.

- The Forensic Coordinator will make contact with the MHFPC Forensic Coordinator to begin monitoring the restoration process. The Forensic Coordinator will maintain communication with the MHFPC Clinical Team throughout the defendant's stay.

- MHFPC will notify the Forensic Coordinator when Fitness to Proceed has been determined and when paperwork is forwarded to the Court. The Forensic Coordinator will monitor for timeliness of the process – fit paperwork sent to court, order to produce issued by court, defendant returned to jail, and competency court hearing scheduled. The Forensic Coordinator will also try to anticipate any discrepancy regarding fitness among the principles involved and intervene when appropriate.

- The Jail Clinical Team will notify the Forensic Coordinator of the defendant's return to OCJ. Forensic Coordinator will notify Senior Secretary / Administrative Assistant.

- If the defendant is found competent at the Competency Court Hearing, the defendant will return to OCJ and the Jail Clinical Team will continue with Competency Maintenance Program.

- If defendant is found incompetent at the Competency Court Hearing, Court will issue an Order of Commitment or an Order of Retention for return to MHFPC. The Forensic Coordinator will make contact with the MHFPC Forensic Coordinator to begin monitoring the restoration process. The Forensic Coordinator will maintain communication with the MHFPC Clinical Team throughout the defendant's stay.

- The cycle above will repeat for each CPL 730 Court Order or Fitness to Proceed determination.

- The Forensic Coordinator may be present at Court for any of the proceedings involving CPL 730.

Jail Clinic CPL 730 Policy Procedure

Policy:

The Orange County Jail Clinic plays a significant role in the management of the mental health needs for defendants involved in the Article 730 CPL process. The implementation of a competency maintenance program shall promote the defendants competency to complete court proceedings.

Procedure:

- When OCDMH receives a court order for a CPL 730 for defendants involved in County Court and those who begin in a lower court, but are indicted with a felony, the support staff will notify the Forensic Coordinator, Senior Secretary / Administrative Assistant, Commissioner, and the Jail Clinic by email and fax the order to the Jail Clinic. The order that includes the statement "Orange County Jail Clinic Records, if any, shall be provided to the CPL 730 Examiners" gives the Evaluators access to the record and communication with the Jail Clinical Team.

- The Forensic Coordinator will make contact with the Jail Clinic, confirming receipt of the current order and request information regarding jail clinician assigned.

- The Jail Clinic will implement the Competency Maintenance Program as outlined below and provide the Forensic Coordinator with the date the Competency Maintenance Program was implemented. The Forensic Coordinator and Clinical Team at the Jail Clinic will continue to communicate about the defendant's course of treatment, especially as it relates to compliance vs. non-compliance with Jail Clinic services and the date medication is taken.

- Jail Clinic Competency Maintenance Program will include the following:

    - CPL defendants will be seen daily during morning rounds.
    - Jail clinician completing rounds will check in with the CPL defendant and notify the assigned clinician and/or the doctor if they note need for an intervention.
    - The assigned clinician and doctors will actively engage with the defendant to build rapport and encourage compliance with appropriate services to support stabilization of mental health symptoms.
    - The assigned clinician will be aware of all court dates and provide additional counseling / support to the defendant anticipating potential decompensation as defendant's anxiety rises.

- The support staff will schedule the 730 evaluators to conduct predominantly independent examinations of the defendant approximately two weeks prior to the court return date. The support staff will notify the Forensic Coordinator, Senior Secretary / Administrative Assistant, and the assigned jail clinician (as noted in the file) of the evaluation date(s).

- Jail Clinical Team will e-mail or fax the Jail Clinic Mental Health Appraisal form and the Jail Competency Status form to the support staff within five days of the scheduled examination date.

- If the defendant is found competent at the Competency Court Hearing, the defendant will return to Orange County Jail (OCJ) and the Jail Clinical Team will continue with Competency Maintenance Program.

- If the defendant is found incompetent at the Competency Court Hearing, Court will issue an Order of Observation or an Order of Commitment. The defendant will return to OCJ to await a hospital designation from the New York State Office of Mental Health Bureau of Forensics. The defendant will be transported to Mid-Hudson Forensic Psychiatric Center (MHFPC). The Jail Clinical Team will notify the Forensic Coordinator of the defendant's transfer date. Forensic Coordinator will notify Senior Secretary / Administrative Assistant.

- When MHFPC submits the Fitness to Proceed paperwork to the Court, the defendant will be returned to OCJ to await the Competency Court Hearing. The Jail Clinical Team will implement Competency Maintenance Program, notify the Forensic Coordinator of the defendant's return date, scheduled court date, Jail Clinician assigned, and the date Competency Maintenance Program was implemented. Forensic Coordinator will notify Senior Secretary / Administrative Assistant.

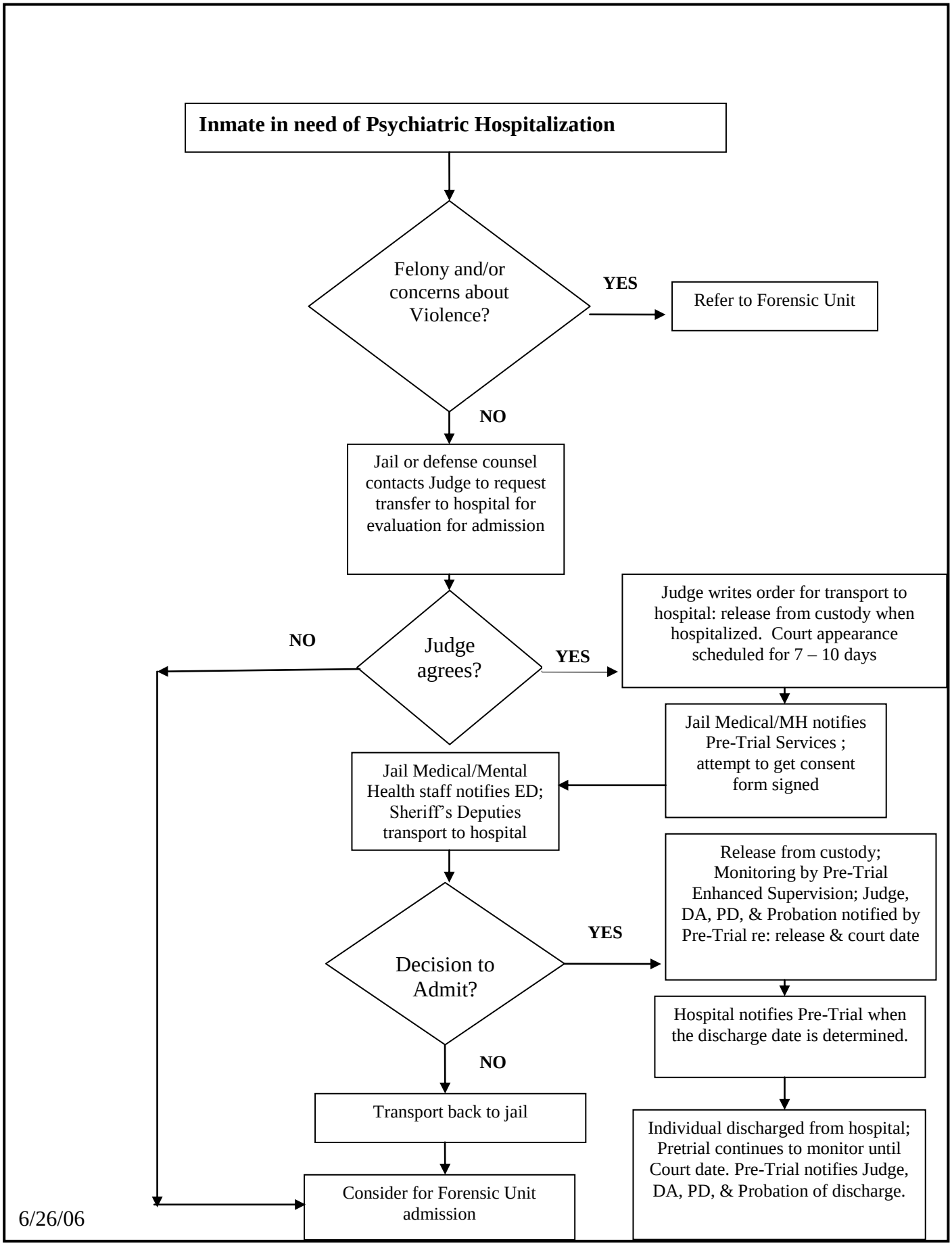
- If the defendant is found competent at the Competency Court Hearing, the defendant will return to OCJ and the Jail Clinical Team will continue with Competency Maintenance Program. If defendant is found incompetent at the Competency Court Hearing, Court will issue an Order of Commitment or an Order of Retention for defendant to return to MHFPC. The Jail Clinical Team will notify the Forensic Coordinator of the court determination. Forensic Coordinator will notify Senior Secretary / Administrative Assistant.

- The Jail Clinical Team will provide the defendant's disposition and date to the Forensic Coordinator when the defendant's charges have been resolved. Forensic Coordinator will notify Senior Secretary / Administrative Assistant.

Appendix 12

Releasing Individuals from Custody for the Purposes of Hospitalization
A Flow Chart & Court Order from Monroe County

Releasing Individuals from Custody who are in Need of Acute Psychiatric Hospitalization



6/26/06

Release for Purposes of Stabilization

STATE OF NEW YORK
COUNTY OF MONROE **_____COURT**

_____

THE PEOPLE OF THE STATE OF NEW YORK

-vs- **Ind./Docket No.**

_____, dob _____,

Defendant.

ORDER

Defendant was held on charges of: _____ out of the jurisdiction of (Supreme/ County/ City/ Town/ Village _____.

ORDERED, that the defendant who is now held in the custody of the Monroe County Sheriff will be released forthwith (or within the next 72 hours as soon as a local inpatient bed is located). The defendant is released by Hon. _____ on the following conditions:

Defendant to be admitted to Rochester General Hospital, St. Mary's, or Strong Memorial Hospital **(circle one)** for treatment of his/ her mental illness;

Defendant shall execute a waiver of confidentiality at the appropriate time for information to be received by the court confirming that the defendant is admitted to the hospital for inpatient hospitalization and communicating the release date or continued treatment of said defendant to **Kimberly W. Butler, LCSW, M.S. Chief, Clinical & Forensic Services, Monroe County Office of Mental Health Priority and Socio-Legal Services** 80 W. Main Street, 4th Floor Rochester, NY 14614.

Defendant upon his/ her release from inpatient psychiatric hospitalization is remanded to the custody of the Monroe County Sheriff **on the same terms and conditions as previously set;** ****OR (Choose one paragraph delete the other)******

Defendant upon his/her release from inpatient hospitalization shall cooperate with the Supervision Program of Pre-Trial Services Corporation and must report to them within 24 hours of release from hospitalization whether voluntarily or against medical advice;

In the event the defendant is not admitted to the hospital, the defendant is remanded to the custody of the Monroe County Sheriff on the same terms and conditions as previously set.

DATED: _____ _____

Hon. _____

Release for Purposes of Stabilization

This is to confirm that defendant is being admitted to the psychiatric inpatient unit at _____ Hospital.

Signed: _____ Date: _____