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**Testimony of Beth Haroules On Behalf of the New York Civil Liberties Union Before the New York City Council Committee on Mental Health, Disabilities and Addiction Regarding Oversight – Plans to Address the Mental Health Crisis.**

**February 25, 2022**

The New York Civil Liberties Union (NYCLU) appreciates this opportunity to submit the following testimony regarding the coordination of New York City's agencies to address serious mental illness.

The NYCLU, the New York State affiliate of the American Civil Liberties Union, is a not-for-profit, nonpartisan organization with eight offices throughout the state and over 180,000 members and supporters. The NYCLU defends and promotes the fundamental principles and values embodied in the Bill of Rights, the U.S. Constitution, and the New York Constitution, including the right of every New Yorker to enjoy life, liberty, due process, and equal protection under law. This includes our work in pursuit of community safety, and our work to advance the rights of New Yorkers who experience mental health issues. The NYCLU has long been a coalition partner of both Correct Crisis Intervention Today – NYC (CCIT-NYC) and Communities United for Police Reform (CPR).

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We hope that this Council will begin a period of robust and frequent monitoring of the City's response as a whole to the mental health challenges confronting so many New Yorkers. New York City's public mental health services are simply dysfunctional -- from policies to procedures to programs to facilities -- and the system's negative impact on the City's Black, Brown, AMEMSA, AAPI and Indigenous community members is quite deeply entrenched.

The Mayor's Office of Community Mental Health (MOCMH) and the new interagency Mental Health Council established by Executive Order 68 and Local Law 155 (2021), offers New Yorkers the opportunity to develop a truly comprehensive mental health system in NYC – one that is based on prevention, one that includes an appropriate and comprehensive strategy for responding to people experiencing mental health crises, one that actually does

not embed and perpetuate the NYPD's involvement as responders, and one that uses a racial equity framework to inform its design and performance.

But coordination is key to this effort and we strongly suggest that the Council must first amend Local Law 155 to make MOCMH truly a mayoral-level agency – and to ensure a diverse oversight body that includes peers, providers, and community members – the people who are generally never invited to the table and allowed to take part in the conversations and planning that too often are conducted about them without them.

MOCMH must be able to coordinate strategies across multiple city agencies and must have the authority to bring all the relevant stakeholders to the table and secure their cooperation to reform existing procedures and protocols and to coordinate and implement the strategies required for people with complex social, economic, and health needs. This task is far beyond the capacity of an office that seems to be embedded somewhere within an agency or office headed by some as yet unnamed or undetermined mayoral appointee.

We also suggest that this Committee closely examine the following issues:

- the continued inappropriate embedding of the NYPD in the City's response to mental health calls including the ICAT training program that NYPD unilaterally adopted in June 2021 without releasing any detail to the Council or to the public;
- the failures of transparency and public reporting by MOCMH's B-HEARD [Behavioral Health Emergency Assistance Response Division] pilot project that is currently deploying teams of health professionals - including EMTs/paramedics and mental health professionals - to 911 mental health calls as opposed to a true health informed response; and
- perhaps most importantly at the present moment, the appropriate role for the MOCMH, and the City Council, in shaping homeless initiatives, particularly those that involve the involuntary removals for psychiatric observation of those individuals who are or are deemed to be homeless, that are going to be carried out under N.Y. State Mental Hygiene Law with so-called SOS teams,[1] which may include nurses who may or may be school nurses as was reported last week,[2] and which may or may not operate under the auspices of New York State Office of Mental Health or New York City Health and Hospitals and the New York City Department of Homeless Services.

These points are discussed more fully below.

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[1] *See Governor Hochul Announces Expanded Initiatives to Address Street Homelessness*, https://www.governor.ny.gov/news/governor-hochul-announces-expanded-initiatives-address-street-homelessness.

[2] *Adams to send social worker-nurse-cop squads to target subway homeless crisis*, Bernadette Hogan, Nolan Hicks, Bruce Golding, New York Post, February 17, 2022, https://nypost.com/2022/02/17/adams-enlisting-nurses-social-workers-to-ease-homelessness/.

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*The Mayor's Office of Community Mental Health*

In New York City, police continue to be the first to respond to the scene of someone in a mental health crisis, and many transport individuals to an emergency room, jail, or psychiatric hospital. But police are not mental health counselors or social workers; they lack the comprehensive training and skills needed to provide the safe and appropriate response to those in distress.[3] Moreover, the presence of armed police officers too frequently escalates crisis situations. In worst-case scenarios, officers use force in response to a person in crisis, resulting in unnecessary and unjust serious bodily injury and death to those who simply need the care and support of trained health professionals (*e.g.* social workers and psychologists).

Even if an individual is connected to mental health services, the mental health care that is currently delivered, especially for people reliant on the public mental health system, is routinely second-rate, dismissive of choice or convenience, difficult to obtain in many neighborhoods and rarely linguistically competent, culturally competent, gender competent, or, in any way, person-centered. Preventive care will keep people healthy and well through the provision of social supports, starting with economic security, safe affordable housing, available employment, meaningful social connections, and the ability to access beneficial services in one's own community.

As noted above, MOCMH and the new interagency Mental Health Council established by Executive Order 68, May 5, 2021 and Local Law 155 (2021),[4] present an opportunity to develop a truly comprehensive mental health system. A mayoral-level agency must be empowered to coordinate the strategies required for people with complex social, economic, and health needs. Because proper care and support is not available when and where it's needed, people with mental illness cycle through myriad public systems, sometimes for decades, including the courts, jails, certified CPEPs or Comprehensive Psychiatric Emergency programs, hospital emergency departments and inpatient units, shelters, and many offices within the Department of Social Services.

But MOCMH does not have meaningful power.[5] As noted above, MOCMH should be coordinating strategies across multiple city agencies and must have the authority to bring all

[3] Police have limited options, all grounded in traditional policing models of command, control and coercion principles, when responding to a person in crisis. They may arrest the individual; refer the person to mental health services or transport the person for an involuntary psychiatric evaluation; resolve the situation informally, for example, asking the individual to leave the scene; or if the individual is a crime victim, take a report and perhaps provide assistance.
[4] Local Law 155 does not take effect until on or about March 22, 2022.
[5] Although Local Law 155 amends the City Charter to create MOCMH, MOCMH may be "established within the executive office of the mayor or as a separate office or within any other agency or office headed by a mayoral appointee as the mayor may determine." MOCMH's director will either be "appointed by the mayor or by the head of such other agency or office."

the relevant stakeholders to the table and secure their cooperation to reform existing procedures and protocols. MOCMH appears to have been buried somewhere within an agency or office headed by some as yet undetermined mayoral appointee.

The interagency Mental Health Council as established by the Executive Order is composed entirely of city employees[6] and Local Law 155, which has not taken effect as of yet, is silent as to the composition of this Mental Health Council. Policy. Planning also appears to continue to originate in a top down fashion conducted entirely by city employees who are not likely to have any meaningful connection to the impacted neighborhoods and the people most in need. The communities disproportionately impacted by mental health concerns are integral to the development of an action plan that focuses both on the systems at work, together with the underlying social determinants of health which undermine mental health care: lack of accessible services, limited housing options, virtually non-existent social supports, high unemployment and underemployment, racism, and police violence. Notably, those with the highest needs, including people who are homeless or recently incarcerated, have the least access to care.

MOCMH and the Mental Health Council are charged, among other things, with identifying critical gaps in care that are preventing New Yorkers with mental health needs from accessing and staying connected to care, incubating innovative strategies to close these gaps in care, maximizing the promotion of mental health within and across City agencies by developing citywide policies and practices, including coordinating agencies to effectively and equitably maximize mental health crisis prevention, intervention and stabilization practices; promoting mental health screening; increasing referrals to care; offering relevant training; implementing other strategies that promote mental health; and eliminating barriers to care through engagement with under-served populations.

An initiative of this nature must be evidence-based, person-centered, and community-driven. The Mental Health Council to be constituted under Local Law 155 must meaningfully include peers, community members, and subject experts in a policy-making role as the Mental Health Council cannot be permitted to operate without any consultation with subject experts, community-based providers, and, most critically, New Yorkers who have had firsthand experience with the mental health system and encounters with crisis responders.

New Yorkers seeking mental health services, from preventative, to crisis to post-crisis stabilization and wrap around services, deserve the care and support of trained, community-

[6] E.O. 68 provides that Council membership shall include City office or agency Commissioners or their designees from agencies including, but not limited to, the Department of Health and Mental Hygiene, the Human Resources Administration, the Administration for Children's Services, the Police Department, the Fire Department, the Mayor's Office of Criminal Justice, and the Department for the Aging. Representatives of the Department of Education and the New York City Health & Hospitals Corporation are invited, but not mandated, to participate in the Council. The New York City Department of Health and Mental Hygiene serves as a "technical advisor" to the Council.
Local Law 155 does not list participating city agencies but notes that the "mental health council shall consist of delegees of any office or agency the director determines the participation of which would aid such office's efforts."

based, culturally competent, language accessible, and gender competent health professionals. New Yorkers deserve a well-funded system of respite care centers, mental health urgent care centers, drop-in centers for those with mental health concerns and safe havens for people with mental health concerns. These services must be easy to access, open to the public 24/7, and prioritize serving those neighborhoods that struggle most with crises. A service delivery system of this sort would provide people with mental health conditions resources and support that can stop crisis situations from emerging. Development, and investment, in community-based organizations that improve overall quality of life will subsequently improve citywide mental health, and must be prioritized.

We urge the Council to amend Local Law 155 to make MOCMH truly a mayoral-level agency and to replace the current advisory body composed entirely of government agency heads with a diverse oversight body that includes peers, providers, and community members, such as was recommended in 2018 by the Mayor's Task Force on Crisis Prevention and Response.

*Failure of Transparency and Reporting by B-HEARD*

MOCMH launched the B-HEARD pilot project in June 2021. In this model, both mental and physical health professionals are charged to respond to 911 mental health emergency calls. The goals of the B-HEARD pilot are to route 911 mental health calls to a health-centered B-HEARD response whenever it is appropriate to do so and increase connection to community-based care, reduce unnecessary transports to hospitals, and reduce unnecessary use of police resources.[7]

MOCMH has posted only a datasheet on the first six month of B-HEARD's operations.[8] The NYPD has previously taken public issue with the accuracy of the data reported by MOCMH[9] and B-HEARD's own data sheet notes that only 22% of all 911 have been routed to a B-HEARD response team.[10] B-HEARD has apparently established some sort of advisory board which has met only once. Most of the operations of B-HEARD are cloaked in secrecy.

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[7] *See* https://mentalhealth.cityofnewyork.us/b-heard. The B-HEARD pilot largely continues to embed an NYPD response in the pilot as calls that involve a weapon, an imminent risk of violence, or where NYPD or EMS call-takers know that an individual has an immediate need for a transport to a medical facility will continue to receive a traditional 911 response—an ambulance and police officers. The B-HEARD pilot is not a true non-police response model that is similar to the CAHOOTS Whitebird Clinic Model, nor is it at all similar to the non-police response model advanced by CCIT-NYC.

[8] *See B-HEARD, Transforming NYC's Response to Mental Health Crises, FIRST SIX MONTHS OF OPERATIONS,* https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/12/FINAL-DATA-BRIEF-B-HEARD-FIRST-SIX-MONTHS-OF-OPERATIONS-12.15.21-1.pdf.

[9] "First responders in a new city program aimed to keep cops from answering 911 mental health calls are repeatedly calling for police assistance," NYPD Commissioner Dermot Shea said. *See NYPD still called in to help with police-free emergency mental health response teams,* Thomas Tracy, New York Daily News, June 24, 2021, https://www.nydailynews.com/new-york/nyc-crime/ny-first-responders-pilot-program-call-police-20210624-w3n7z5v7tfhrno5t5vqfiwk4ty-story.html.

[10] *See* https://mentalhealth.cityofnewyork.us/wp-content/uploads/2021/12/FINAL-DATA-BRIEF-B-HEARD-FIRST-SIX-MONTHS-OF-OPERATIONS-12.15.21-1.pdf.

What is B-HEARD actually doing and how well is B-HEARD actually performing? Members of CCIT-NYC have previously posited a number of questions to B-HEARD personnel that have not been answered. Perhaps the Committee can obtain answers to the questions that advocates have been unable to obtain. The CCIT-NYC questions that are still outstanding from last fall are attached to this testimony at exhibit A.

*NYPD's ICAT Training Program*

Currently, NYPD officers and the New York City Fire Department's Emergency Medical Services Emergency Medical Technicians (EMTs) still respond to nearly all mental health 911 calls, regardless of the severity of health needs, whether a crime is involved, or whether there is an imminent risk of violence.

For the past five years, the City adopted a crisis intervention training ("CIT") program intended to train NYPD officers in de-escalation techniques they should use while interacting with people experiencing a mental health crisis. Since this training program began, 16 New Yorkers in a mental health crisis were killed during confrontations with police and another three were shot and critically wounded — compared to seven people killed in the seven years prior to when the program began. That training program was terminated, without public notice, at some point during the pandemic.[11]

In June, 2021, then-NYPD Chief Dermot Shea indicated that the NYPD will be training all 35,000 of its officers in new de-escalation tactics to avoid use of force. The new program is called ICAT-Integrating Communications, Assessment and Tactics. The ICAT training has apparently already been rolled out to the Emergency Services Unit. It is not clear whether the former CIT training has been fully terminated. Whatever the training module deployed by NYPD, the NYPD remains deeply entrenched in NYC's mental health crisis response model.

There is no forward-facing information on the NYPD website about the ICAT training.[12] Indeed, most of the available information is set forth on the website of the Police Executive Research Forum (PERF) is an independent research organization that focuses exclusively on

[11] In 2015, after years of pressure from advocates, the NYPD agreed to train its officers on how to interact with and de-escalate situations where people apparently experiencing a mental health crisis. According to the City and the Mayor's Management report, around 18,000 NYPD officers have received the training since then, at a cost of $5.3 million dollars a year. But, the City had fallen years behind its goal of training 23,000 NYPD patrol officers by 2018, and the efficacy of the program was questioned by some of the same advocates who initially pushed for it. This training program was abruptly terminated and all NYPD staff affiliated with the program reassigned to other duties at some point during the pandemic. Although NYPD has indicated that the program will be resumed, whether the program has been halted indefinitely or canceled outright is still unclear. *See NYPD Abruptly Halts Training Program Meant To Help Police De-Escalate Encounters With People In Mental Health Crisis*, Gwynne Hogan, WNYC, September 25, 2020, https://gothamist.com/news/nypd-abruptly-halts-training-program-meant-help-police-de-escalate-encounters-people-mental-health-crisis.

[12] Indeed, the NYPD Specialized Training Section indicates that it is still engaged only in the CIT training that was cancelled during the pandemic; ICAT is mentioned nowhere on the NYPD website. *See* https://www1.nyc.gov/site/nypd/bureaus/administrative/training-specialized.page.

policing issues.[13] Whatever this ICAT training may be, it certainly was not developed in consultation with any impacted communities' members, much less the recently created Mayor's Office of Community Mental Health or the new interagency Mental Health Council – to which the NYPD belongs. We know this because PERF was already training the NYPD as of June 21, 2021 according to PERF.

NYPD Assistant Police Chief Kenneth Corey, then-head of training for the NYPD, is quoted in a Washington Post article,[14] noting that it "would take about two years for the entire NYPD to go through ICAT training and that commanders would closely monitor the impact it had citywide."

Chuck Wexler, the head of PERF, is quoted in that same Washington Post article as follows:

> "If you want to get at the heart of police reform," Wexler said, "it's the use-of-force issue. It's not about the homeless, or the schools or qualified immunity. **It's about all these 'lawful but awful' shootings**, that 40 percent of people who don't have guns. Cops are doing what they're trained to do. And for New York, that's a department that wants to be at the forefront."

This quote demonstrates quite clearly that law enforcement officers' training is fundamentally incompatible with a public health response to people in crisis. This Committee should reject the concept of "lawful but awful shootings" of people in mental health crisis. The Committee should do all in its power to stop the NYPD's ICAT training.

The NYPD is moving forward, apparently entirely unchecked, to maintain, and embed, its outsize and unwarranted role in mental health crisis response. The entrenchment of the NYPD in mental health crisis response in New York City flies in the face of nationwide initiatives to fundamentally transform the role of policing in New York City and New York State – we must start by ending our over-reliance on police as first responders in every crisis. The NYPD can no longer be tasked with responding to calls of residents experiencing a mental health or substance use crisis. The City must, instead, immediately establish a civilian crisis system that deploys culturally competent and gender competent social/crisis workers, medics, and mental health peers; not law enforcement officers who specialize in addressing crime. Such crisis response professionals must have the training and expertise to safely stabilize individuals in crisis and connect them to services and/or treatment, if necessary, and to do so in a way that dramatically reduces the risk of serious injury and

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[13] *See* June 26, 2021 *Dear Perf Members letter re Addressing the Defining Issue in Policing Today*, available at https://www.policeforum.org/trending26jun21. The Washington Post has covered the NYPD's embrace of PERF's ICAT training curriculum. *Amid rising police violence, New York City police to train entire force in de-escalation,* Tom Jackman, June 23, 2021, https://www.washingtonpost.com/nation/2021/06/23/new-york-police-deescalate/. That Washington Post article quotes NYPD as indicating that the ICAT training is intended to kick in "only in situations where subject doesn't have a gun."

[14] That Washington Post article quotes NYPD as indicating that the ICAT training is intended to apply "only in situations where subject doesn't have a gun." *Id.,* https://www.washingtonpost.com/nation/2021/06/23/new-york-police-deescalate/.

death to those individuals in crisis and, indeed, to members of the community. The design, implementation, and monitoring of such a crisis response system must be driven by the impacted communities. "Daniel's Law" is an example of a statewide initiative that would provide the opportunity to meet this moment with a bold new vision for community safety that starts with removing police as the default solution to address mental health needs.[15]

New Yorkers want a true reimaging of what is considered public safety and the role of law enforcement – particularly with respect to responding to people in a health crisis. Programs replacing police with social workers, mental health counselors, and medical staff have been in operation for at least a year in Austin, Texas; Eugene, Oregon; Olympia, Washington; and Edmonton, Canada.[16] These programs are all focused on providing more appropriate services and reducing government spending. Other cities have recently begun or approved crisis response programs of their own.[17]

This Committee should not permit the NYPD to dictate the contours of the New York City mental health crisis response system.

*Subway and Street Homeless Initiatives*

Homeless New Yorkers, advocates and service providers are watching with great concern several new and expanded Department of Homeless Services street homelessness initiatives. Details about the Mayor's and Governor's February 18, 2022 MTA subway safety initiatives are not at all readily available.[18] During this Committee's hearing on February 25, 2022,

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[15] "Daniel's Law," A.4697 (Bronson) / S.4814 (Brouk).

[16] Eugene's program has operated since 1989, and in 2019 responded to 20% (24,000) of all 911 calls, with a police backup request rate of 0.625% (160). *See Alternatives to Police as First Responders: Crisis Response Programs*, Matt DeLaus, Albany Law School, November 16, 2020, available at https://www.albanylaw.edu/centers/government-law-center/policing/explainers/Pages/Alternatives-to-Police-as-First-Responders-Crisis-Response-Programs.aspx#_bookmark3 ("Albany Government Law Center Explainer").

[17] *Id. noting* "Cities with non-police crisis response programs in operation less than a year include Portland, Oregon, and Denver, Colorado. *See* https://www.usatoday.com/story/news/nation/2020/06/22/defund-police-what-means-black-lives-matter/3218862001/. Oakland, California, decided to fund a crisis response program, but it is not yet in operation. See https://www.kron4.com/news/bay-area/mobile-response-unit-coming-to-oakland-to-help-with-non-violent-911-calls. Local governments that have decided to fund a crisis response program since George Floyd's killing include Los Angeles, California (https://www.cnn.com/2020/10/14/us/los-angeles-unarmed-crisis-response-teams-911-calls/index.html); Miami-Dade County, Florida (http://www.miamidade.gov/govaction/legistarfiles/Matters/Y2020/201239_Analysis.pdf; http://www.miamidade.gov/govaction/legistarfiles/Matters/Y2020/201239.pdf); Philadelphia, Pennsylvania (https://philadelphia.pa.networkofcare.org/mh/news-article-detail.aspx?id=116033); Rochester, New York (https://www.rochesterfirst.com/news/local-news/watch-live-mayor-warren-to-announce-crisis-intervention-program/); Salt Lake City, Utah; Albuquerque, New Mexico; Hartford, Connecticut; Durham, North Carolina (https://www.prainc.com/wp-content/uploads/2020/08/PoliceReformAcrossUS508.pdf at 2-4); and San Francisco, California (https://www.usatoday.com/story/news/nation/2020/06/22/defund-police-what-means-black-lives-matter/3218862001/). Many other locales are exploring the possibility. *See, e.g.*, https://www.prainc.com/wp-content/uploads/2020/08/PoliceReformAcrossUS508.pdf."

[18] The 17-page Subway Safety Plan has no additional details beyond what Mayor Adams and Governor Hochul announced at the press conference. *See* https://www1.nyc.gov/assets/home/downloads/pdf/press-releases/2022/the-subway-safety-plan.pdf.

Mayor Adams announced, with scant detail, an additional initiative to break up all the so-called homeless encampments within the subway system. All the observations and information learned so far suggest we are about to witness a troubling escalation of sweeps and criminalization of unsheltered New Yorkers who have sought safety in the subway system.

We urge this Committee to exercise its oversight authority to understand what involvement by MOCMH and the Council, and its individual members, is occurring and what an appropriate role for MOCMH and the Council should be, with respect to the operation and oversight of the MTA Subway Safety Plan as well as other recent homeless initiatives including homeless outreach, clean-ups, and "sweeps"; healthcare provision; other targeted initiatives such as the Penn Station Initiative, Expanded Subway Initiative, Daily Priority Cleanings Initiative, and the 311 Service Request Operation.

It is of particular importance, we submit, that this Committee understand the scope and operation of homeless initiatives that involve the involuntary removals of those individuals who are or are deemed to be homeless to psychiatric facilities, pursuant to Article 9 of the N.Y. State Mental Hygiene Law. We understand that these involuntary removals are being carried out with the assistance of street health nurses who may or may not operate under the auspices of New York City Health and Hospitals and the New York City Department of Homeless Services.

The New York State Office of Mental Health ("OMH") issued "Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions" ("OMH Interpretative Guidance") to NYPD and to NYC H+H and other health facilities and providers late in the day on February 18, 2022 and well after the press conference announcing the new subway sweep initiative was announced. The OMH Interpretative Guidance addresses what are commonly called Mental Hygiene arrests.[19]

The OMH Interpretative Guidance troublingly suggests an expansion of the state's authority to remove people for psychiatric observation. But the fact that an unhoused person who cannot, economically, procure housing and chooses the safety of the subway vs. the dangerousness of city congregate shelters does not constitute *per se* evidence of mental illness. Pretextual removals on this ground would be contrary to long established federal and state constitutional rights and norms.[20]

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[19] For the Committee's convenience, I am attaching a copy of the OMH Interpretative Guidance as exhibit B. See also https://omh.ny.gov/omhweb/guidance/interpretative-guidance-involuntary-emergency-admissions.pdf.

[20] OMH's interpretation of the cited caselaw is an aggressive one. In *Matter of Scopes v. Shah*, 59 A.D.2d 203, 398 N.Y.S.2d 911 (3d Dep't 1977), for example, the Appellate Division indicated that "our concepts of due process would not tolerate the confinement of an individual thought to need treatment where the sole justification for such deprivation of liberty is the provision of some treatment." In *Boggs v. Health Hosps. Corp*., 132 A.D.2d 340, 523 N.Y.S.2d 71 (1st Dep't 1987), the Appellate Division noted that "loss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior." The Appellate Division

It is magical thinking to assume that the subways will not function as housing when the City and State simply offer nothing other than involuntary transport to a psychiatric facility for "observation" under threat of compelled psychiatric treatment. The broader housing goals offered by Governor Hochul and Mayor Adams in the so-called Subway Safety Plan will take far longer to implement while NYPD enforcement activities are essentially ramping up overnight.[21]

We urge the City Council to continue to keep intense focus on the investment of resources and connection of people with consensual care – proven approaches to help people in the long term. And we urge the City Council to push back against what appears to be the Mayor's and Governor's intent to recraft a mental health system to permit easier removal and forced treatment of people without addressing systematic dysfunctionality – the lack of supportive housing and culturally appropriate supports and services. Short-term forced treatment and criminalization are demonstrably ineffective approaches to meaningful change.

*Conclusion*

The NYCLU thanks the Committee for the opportunity to provide testimony. We stand ready to working with the members of this Committee, and all appropriate partners, to advance meaningful policy changes that will improve the lives of New Yorkers confronting housing, mental health and or substance use challenges.

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concluded that, "the sole issue before us is whether Ms. Boggs is **so severely mentally ill** that, unless she continues to receive hospital treatment, she is in danger of doing serious harm to herself" (emphasis supplied). Similarly, in *In re Application of Consilvio v. Diane W.*, 269 A.D.2d 310, 703 N.Y.S.2d 144 (1st Dep't 2000), the Appellate Division emphasized that there must be a diagnosed mental health condition in order to permit detention for involuntary treatment. "In order for a hospital to detain a patient for involuntary psychiatric care, it must be demonstrated, by clear and convincing evidence, that the patient is mentally ill and in need of continued, supervised care and treatment […]. In *In re Carl C.*, 126 A.D.2d 640, 511 N.Y.S.2d 144 (2d Dep't 1987), the Appellate Division emphasized that "in order for the State to confine a person to a mental institution against his will, the law requires more than a mere showing of mental illness. Rather, the State must prove, *by clear and convincing evidence*, that the person is mentally ill and that he poses a substantial threat of physical harm to himself or others" [original emphasis].

[21] As noted by Governor Hochul at the February 18, 2022 press conference, the Governor's proposed New York State budget calls for a 5 year roll out of a $25 billion housing plan with a commitment to create and preserve 10,000 units of supportive housing over the next five years to prevent homelessness. The need for supportive housing is now.

Governor Hochul has also proposed putting 600 hospital beds that private medical facilities were allowed to dispose of during the pandemic back online. But hospital stays cannot be used as a remedy for homelessness in place of appropriate community housing and support models.

Mayor Adams has indicated that NYPD officers will join city dispatched "SOS teams," joint response teams that include homeless services and health department workers to conduct outreach to homeless people on the subway but those teams have yet to be staffed and trained.

And, while Mayor Adams claims that New York City will add 490 safe haven and "stabilization" beds, shelters that provide mental health treatment, as well as the creation of new drop-in centers for homeless people at key subway stations through a $100 million state investment, his proposed budget offers nothing except a grossly expanded NYPD budget.

**Exhibit A: Questions relating to the B-HEARD project.**

**Recruitment and Training of Staff and Officers**

- Composition of team members – language, culture, ethnicity, community background, and lived experience.
- What has been the turnover rate? Reasons for turnover.
- Will there be an opportunity to observe training that the social workers and EMTs receive?
- How does the NYPD ICAT training incorporate the B-HEARD pilot?
- Will the NYPD's prior CIT training resume and who will be conducting the training?
- Will B-HEARD be incorporated into the ongoing training of officers?
- Is there any cross training between B-HEARD and NYPD first responders?
- Press reports suggest EMTs concerned about their safety and not many applied to B-HEARD. Is this true, and if so, has the experience of working with B-HEARD changed the attitude of EMT staff?

**Operational Issues**

- What is the NYPD's role(s) in the pilot? Is there an ongoing assessment and feedback process to analyze the BH/MH-related calls to better target resources?
- Have officers at the Housing Authority's Police Service Areas (#5 and #6 in Upper Manhattan) been included in the training or planning for the pilot?
- Can a flow chart / decision tree be developed to show how the system works: from calls to dispatch to follow up?
- List of community resources currently being used.
- If B-HEARD team requests an ambulance, do police also come?
- Can an ambulance transport to connection center or only to hospital?
- Uniform for EMT and social worker.
- Can callers request a B-HEARD team via 911, 311, or NYC-WELL?

**Data and Outcomes**

- It would be helpful to have a dashboard presentation on the website that tracks the outcomes of the pilot with key indicators. How do we measure success? One suggestion is that MH/BH-related calls to 911 drop to zero in the pilot area.
- During the first month, the total number of MH/BH calls = 560, of which 25% (138) routed to B-HEARD teams. The goal is to route at least 50%. Why was this metric selected, as opposed to 80%, 90%, or 100%?
- Average time from dispatch to arrival on scene.
- The types of locations to which teams are dispatched—are there any clear trends?
- How are calls resolved—any trends based on the type of calls, location, or other factors?
- Average amount of time a team spends on a call?
- Percent of people who are homeless? For those, the percent connected to permanent housing.

- Were any "hot spots" identified?
- Frequent users?

**Dispatch Protocols**

- The description of when police will continue to be sent is not precise: "…emergency situations involving a weapon or imminent risk of harm to themselves and/or others…" and "…violence and/or imminent suicide or harm…" and "…violence, weapons, imminent harm, criminality, or other circumstances requiring law enforcement assistance…"
- Overall, can there be more clarity on dispatch protocols to determine risk of violence?
- The FAQs distinguish between a "mental health emergency" and a "behavioral health crisis," with the former, but not the latter, requiring a call to 911. Is there a clear distinction between the two?
- Of the 138 calls routed to B-HEARD, 20% re-routed to NYPD because teams were not available at the time. The CAHOOTS protocol is to establish a queue and respond to each call when a team is available, which might be an hour or more.
- Press statement by NYPD Commissioner Shay said that the B-HEARD teams frequently call for police support (80% of the time), however the data indicates this only happened 7 times. What is the correct number and why don't the NYPD stats agree with the B-HEARD stats?

**Services and Support**

- "In 95% of cases, people received assistance from B-HEARD teams…"
- 25% counseled on-site
- 25% transported to support services
- 50% transported to a hospital
- "Everyone served by B-HEARD was offered follow-up care…"
- What type of assistance did people typically receive?
- How often have Health Engagement and Assessment Teams been used and what has been their effectiveness in engaging people in ongoing support? Who is tracking these outcomes? ("…HEAT services are generally in place for up to 90 days, depending on the person's level of engagement and need…")
- Is there any overlap with mobile crisis, intensive mobile treatment, and co-response teams that are assigned to same geographic area?
- What has been the role and effectiveness of the support and connection center?
- The agenda for the advisory committee meeting includes a request for social services and other supportive resources from the community. What are the main gaps in services and supports the B-HEARD teams are finding, for example, housing, re-entry supports, substance use treatment, etc.?
- Is it possible to develop a profile of the "typical" person the B-HEARD team is seeing: race, gender, disability, housing stability, substance use, education, and so on?
- Is there a healthcare database or EHR-type file for the individuals contacted by B-HEARD that documents treatment and health issues?

Exhibit B

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

| KATHY HOCHUL | ANN MARIE T. SULLIVAN, M.D. | THOMAS E. SMITH, M.D. |
|---|---|---|
| Governor | Commissioner | Chief Medical Officer |

**Memorandum**

**To**: NYS Public Mental Health Providers

**From**: Ann Marie T. Sullivan, MD, Commissioner, NYSOMH
Thomas Smith, MD, Chief Medical Officer, NYSOMH

**Date**: February 18, 2022

**RE**: Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions

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This guidance is intended to help clinicians, and other community providers, make thoughtful, clinically appropriate determinations relating to involuntary and emergency assessments, while respecting an individual's due process and civil rights.

**Summary**

There is often a misconception amongst both police as well as front-line mental health crisis intervention workers that a person with mental illness must present as "imminently dangerous" in order to be removed from the community to a hospital or CPEP setting for evaluation, admission and treatment, meaning that they need to present an immediate overt risk of violence to others or an immediate overt risk of physical harm to themselves in order for removal to be implemented. This is not the case.

The Mental Hygiene Law provides authority for peace officers and law enforcement officers to take into custody for the purpose of a psychiatric evaluation those individuals who appear to be mentally ill and are conducting themselves in a manner which is likely to result in serious harm to self or others, which includes ***persons who appear to be mentally ill and who display an inability to meet basic living needs, even when there is no recent dangerous act***.

Likewise, Directors of Community Services, as well as physicians or qualified mental health professional who are members of an approved mobile crisis outreach team, have the power to remove or to direct the removal of any person to a hospital for the purpose of evaluation for admission if such person 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, which includes ***persons with a mental illness who displays an inability to meet basic living needs, even when there is no recent dangerous act***.

Limiting the application of the Mental Hygiene Law's (MHL) removal and admission provisions to only those who present as "imminently dangerous" leaves vulnerable persons at risk in the community without an opportunity for assessment, care and treatment, and can also impact the public safety. The New York State Office of Mental Health (OMH) therefore wishes to clarify both removal and involuntary psychiatric admission criteria for individuals who are suspected of

having a mental illness who may not be considered imminently dangerous. Article 9 of the Mental Hygiene Law provides the statutory framework for these provisions, and relevant statutes are summarized within this guidance. For additional clarification, OMH has provided caselaw summaries to provide examples of the practical application of these statutes. [1]

**Background**

Homelessness in New York City has reached the highest levels since the Great Depression; in October 2021, there were over 48,000 homeless individuals in NYC homeless shelters.[2] One third of homeless individuals suffer from a serious mental illness; the numbers are even higher for homeless single adults.[3] Chronically homeless individuals with serious mental illness often have symptoms and cognitive difficulties that further contribute to difficulties accessing treatment and housing resources, placing them at higher risk for poor outcomes including harm to themselves or others.

Involuntary and emergency admissions are governed by New York State laws, regulations issued by OMH, and judicial decisions issued by courts in NYS that interpret those laws and regulations.

- The primary body of laws that govern Involuntary and Emergency Admissions is Article 9 of the Mental Hygiene Law.
- OMH's regulations are set forth in Title 14 of New York Codes, Rules and Regulations.
- There have been a number of important judicial decisions that help define criteria for admission; citations to some of these decisions are included below.

## I. Serious Harm to Self or Others

Under the authority of MHL §§9.37, 9.41 & 9.45, and current case law, police and peace officers have the ability, and with respect to §§9.37 & 9.45 the duty, to take into custody for the purpose of a psychiatric evaluation those individuals who appear to be mentally ill and are conducting themselves in a manner which is likely to result in serious harm to self or others. MHL §9.59 confers statutory immunity from liability to police officers, peace officers, and EMTs, for non-motor vehicle related injuries and death allegedly incurred in the course of such removal, absent gross negligence.

In *Matter of Scopes*, the Appellate Division's Third Department ruled that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others," but that such a finding does not require proof of a recent overtly dangerous act.[4]

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[1] This guidance is intended to provide a synopsis of relevant caselaw and statutory authority and is not meant to constitute legal advice. This guidance memorandum should therefore not be construed as OMH providing legal advice or be relied on as legal authority. All providers should consult their own legal counsel as appropriate.

[2] Coalition for the Homeless. Basic Facts About Homelessness. January 2022. Accessed January 21, 2022 https://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/

[3] Shan LA and Sandler M. (2019). Addressing the Homelessness Crisis in New York City: Increasing Accessibility for Persons with Severe and Persistent Mental Illness. Columbia Social Work Review, 14(1), 50–58. https://doi.org/10.7916/cswr.v14i1.1856

[4] *Matter of Scopes v. Shah,* 59 A.D.2d 203, 398 N.Y.S.2d 911 (N.Y. App. Div. 1977).

The Appellate Division's First Department, in *Boggs v. Health Hospitals Corp.*, held that a person's inability to meet their basic living needs was sufficient to establish dangerousness to self, thereby meeting the involuntary admission standard that the person 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. In that case, Ms. Brown, aka Billy Boggs, was homeless and was allegedly living on a sidewalk grate in winter, running into traffic, making verbal threats to passersby, tearing up and urinating on money that passersby gave her, and covering herself in her own excrement. On January 15, 1988, a state supreme court justice ruled that Bellevue Hospital could not forcibly medicate Ms. Brown and ordered her released from hospitalization, in part because although she was mentally ill, her behavior was not deemed by the court to be obviously and immediately dangerous to anyone. The case was appealed, and the appellate court ruled that Ms. Boggs' behavior met the standard for involuntary admission as she was unable to meet her needs for food, clothing, and shelter, which was deemed sufficient to establish dangerousness to oneself.[5]

Further cases followed and applied the same standard as found in *Boggs* and it is now well settled law[6] that an inability to meet one's need for food, clothing or shelter is sufficient to establish dangerousness to self for purposes of removal from the community for assessment and involuntary admission.

## II. Mechanisms for Removal from the Community

MHL §§9.37, 9.41, 9.45 and 9.58, combined with the established *Boggs* standard in case law, provide the authority to remove and hospitalize people who appear to have mental illness and present a danger to themselves due to substantial self-neglect, with evidence of a recent overt dangerous act not being necessary.

### MHL Section 9.37

Subsection (d) of MHL §9.37 provides that upon the written request of a director of community service or their designee, it shall be the duty of peace officers, when acting pursuant to their special duties, or police officers who are members of the state police or an authorized police department or sheriff's department, to take into custody and transport any such person (for whom there is an application for involuntary admission pursuant to this section) as requested and directed by such director or designee. Ambulance services are also authorized to transport such individuals.

### MHL Section 9.41

Any law enforcement officer may take into custody for an evaluation 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. Likelihood of serious harm includes: attempts/threats of suicide or self-injury; threats of physical harm to others; or other conduct demonstrating that the person is dangerous to him or herself, including a 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 no immediate hospitalization.

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[5] *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).
[6] *In re Application of Consilvio v. Diane W.,* 269 A.D.2d 310, 703 N.Y.S.2d 144 (N.Y. App. Div. 2000), *In re Carl C.*, 126 A.D.2d 640, 511 N.Y.S.2d 144 (N.Y. App. Div. 1987).

**MHL Section 9.45**

A director of community services or their designee has the power to direct the removal of any person for an evaluation if any authorized individual reports that such a 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 himself or herself or others. Authorized reporters include the following: licensed physician, licensed psychologist, registered nurse, or licensed social worker providing treatment, police/peace officer, spouse, child, parent, adult sibling, legal guardian, and supportive or intensive case manager. Peace officers, when acting pursuant to their special duties, or police officers must assist in taking into custody and transporting any such person.

**MHL Section 9.58**

A physician or qualified mental health professional who is a member of an approved mobile crisis outreach team shall have the power to remove or to direct the removal of any person to a hospital approved by the Commissioner for the purpose of evaluation for admission if such person 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.

## III. Involuntary and Emergency Admissions

Admission Standards:

- ***A person with a mental illness who displays an inability to meet basic living needs meets the involuntary admission standard for dangerousness to self.*** The individual is conducting himself or herself in a manner which is likely to result in serious harm to the individual or others.

- ***A person with a mental illness can meet criteria for involuntary admission even when there is no recent dangerous act.*** Courts have found that evaluating psychiatrists may consider an individual's entire history when determining if an individual needs involuntary admission.

The following provisions of the MHL are applicable to involuntary and emergency admissions and are subject to the *Boggs* and *Scopes* standards previously discussed.

**Involuntary Admissions on Medical Certification ("2PC")**

MHL §9.27 sets the standard for involuntary admissions by medical certification (also called a "9.27" or a "2PC") which may be utilized in psychiatric hospital settings, psychiatric emergency rooms and comprehensive psychiatric emergency programs at the point of admission. Under this statute, individuals can potentially be held for up to 60 days, although the patient, a friend or relative, or the Mental Hygiene Legal Service may request a court hearing to contest the involuntary retention at any time during such period.

As per statute, to be involuntarily hospitalized, an individual must have:

- "a mental illness[7] for which care and treatment as a patient in a hospital is essential to such

[7] The term "Mental Illness" is defined in MHL§ 1.03 as "an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation."

person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." (MHL §9.01 and §9.27)

Court decisions have further clarified these requirements. For instance, the Appellate Division's Second Department held in the *Matter of Harry M* that involuntary admissions must be based on a finding that the individual is dangerous, but also that dangerousness is not solely determined based upon whether an individual is expressing suicidal or homicidal ideation.[8] The Court was clear that involuntary admissions were permissible for individuals "whose mental condition manifests itself in a neglect or refusal to care for themselves which presents a real threat of substantial harm to their well-being." ***Patients can meet criteria for involuntary admission even when there is no recent dangerous act.*** Courts have found that evaluating psychiatrists may consider an individual's whole history when determining if an individual needs involuntary admission.[9,10]

The following are examples of individuals who would meet criteria for involuntary admission on medical certification[11]:

- Patient A, who has a history of bipolar disorder and four prior psychiatric admissions, was brought to a medical emergency department (ED) where she was found to be acutely agitated by the consulting psychiatrist. She removed all her clothes, required several rounds of emergent intramuscular medications, and four-point restraints for agitated behavior. The consulting psychiatrist documented that Patient A had paranoia, poor impulse control, was unable to care for her basic needs, and was therefore a potential danger to herself.[12]

- Patient B is a 43-year-old woman with schizoaffective disorder. When unmedicated, she walks onto busy roads and preaches to the passing cars. She has had numerous prior admissions where the religious preoccupations improve, but she always discontinues treatment upon discharge and resumes this activity, which places her in serious danger of being hit by a car. Patient B consistently denies suicidal ideation. Patient B also refuses to engage in planning on how to obtain food and shelter and is insistent on being discharged to a shelter.[13]

- Patient C is a 40-year-old woman who is street homeless and has lived outside a restaurant in Manhattan for the last year. A homeless outreach team has observed her steadily deteriorate and become increasingly disheveled, malodorous, and malnourished. The outreach social worker observed Patient C urinate and defecate on the street, tear up money given to her by people walking by, and become increasingly verbally aggressive, including shouting racial slurs and other obscenities at pedestrians and delivery workers. The mobile crisis team staff are worried she will be assaulted because of her behavior.[5]

- Patient D is a 23-year-old with a prior diagnosis of anorexia nervosa. She was admitted with a weight of 52 lbs (normal for her height would be 100 lbs). Patient D continued to restrict caloric intake and intermittently became hyponatremic from polydipsia in an effort to show weight increase without eating. Patient D showed extreme difficulty gaining insight into the

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[8] *Matter of Harry M*, 96 A.D.2d 201, 468 N.Y.S.2d 359 (N.Y. App. Div. 1983).
[9] *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).
[10] *Matter of Seltzer v. Hogue*, 187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993).
[11] While these examples are derived from the cited published caselaw, some of the facts may have been altered in this guidance for narrative purposes.
[12] *Rueda v. Charmaine D.*, 17 N.Y.3d 522, 958 NE 2d 106, 934 N.Y.S.2d 72 (2011).
[13] *Matter of Yvette S.*, 163 Misc.2d 902, 622 N.Y.S.2d 879 (Sup. Ct, Queens Cnty. 1995).

dangerousness of her behavior and remained resistant to psychotherapeutic or pharmacologic treatment, even though she gained weight and was placed on fluid restriction in the structured unit milieu. Her treating psychiatrist was concerned that without a controlled environment that could impose fluid restrictions and further treatment, Patient D could experience cerebral edema and die.[14]

- Patient E is a 48-year-old man with bipolar disorder and several prior psychiatric admissions who was brought to the ED for treatment of severe hand injuries that required amputation of his left hand and three fingers on his right hand. Five days prior, he had allowed a large firecracker to explode in his hands and did not seek treatment until a family member found him and called 911. The need to amputate resulted from the patient's delay in seeking medical treatment. Two days after the surgery, he eloped from the hospital and was later brought back by police. He was transferred to the hospital's psychiatric unit where he remained irritable, labile, easily agitated, pressured, intrusive, and had disorganized speech. No suicidal ideation or intent was present. [15]

- Patient F is a veteran with a history of traumatic brain injury, schizophrenia, and substance use disorder (cocaine, heroin, PCP, cannabinoids, alcohol, and LSD) who was brought to a CPEP by the police with threatening behavior. Patient F has a 30-year history of extensive prior involuntary admissions and incarcerations for threatening and destructive behavior and shows no insight into having any mental illness or substance use disorders. He previously improved on treatment with lithium and chlorpromazine, but today is not on any medications. He also has a history of immediately discontinuing treatment and relapsing on substances upon discharge from psychiatric hospitals. While currently Patient F denies any suicidal and homicidal ideation, he has a history of masturbating in public, crouching between parked cars and jumping into traffic, siphoning gasoline from cars and using it to light newspapers on fire under other cars, and a history of assaulting and injuring an older woman. He has a prior admission for when Patient F threw a 150lb bench through a neighbor's windshield, bending the frame and breaking the steering system of the car.[16]

**Emergency Admission for Immediate Observation, Care, and Treatment**

MHL §9.39 sets the standard for emergency psychiatric hospitalization (also called a "9.39" or a "1PC"). Individuals alleged to have a mental illness can be held for up to 14 days under this statute for observation, care and treatment. An emergency admission under MHL §9.39 requires that the individual alleged to have a mental illness has engaged in a recent overt dangerous act or behavior and the individual must present either:

- A "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

- 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." (MHL §9.39)

[14] *Matter of Paulina D.*, 104 A.D.3d 883, 961 N.Y.S2d 320 (N.Y. App. Div. 2013).
[15] *New York City Health & Hosps. Corp. v. Brian H.*, 51 A.D.3d 412, 857 N.Y.S.2d 530 (N.Y. App. Div. 2008).
[16] *Seltzer v. Hogue*,187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993)

***However, a substantial inability to provide for one's basic needs because of a mental illness can be considered conduct demonstrating that a person is dangerous to themselves.***

Examples of individuals who may meet criteria for an emergency psychiatric admission include:

- Patient W is a 19-year-old brought to the ED by police after yelling and shaking their fists at several customers in a supermarket. Patient W also pushed over a shopping cart, damaged products, and tried to break a display case.

- Patient X is an 87-year-old who was brought to the ED by his son after the son found a suicide note. Patient X recently gave away his money to charity and bought a gun.

- Patient Y is a 40-year-old with schizophrenia who has disengaged from care. Patient Y was brought to the ED by EMS with hypothermia because he was grossly disorganized and unable to locate shelter despite the freezing cold weather.

- Patient Z is 38-year-old with schizoaffective disorder. She is convinced N, an acquaintance, is a spy from the devil and Patient Z plans to "exorcise N from the earth." Patient Z has purchased a gun and has been carrying it in the event she runs into N.

**Emergency Admission to a Comprehensive Psychiatric Emergency Program**

MHL §9.40 provides for emergency admission to a comprehensive psychiatric emergency program (CPEP). Emergency admission to a CPEP uses the same standard as a MHL §9.39 emergency admission but differs in that individuals may only be held for observation, care and treatment for up to a maximum of 72 hours under this statute and upon the expiration of such time the individual must be discharged or else converted to MHL §§9.27 or 9.39.

The following is a hypothetical based upon caselaw of an individual who would meet criteria for an emergency admission:

- An individual was brought to a CPEP by EMS after a series of provoked verbal and physical altercations with another tenant in their housing development. The individual was interviewed by a medical student and subsequently by a doctor with the medical student present. Based upon the second interview, the doctor determined that the individual had demonstrated poor judgment and that this judgment combined with grandiosity could be a sign of hypomania, which the doctor believed was a potentially dangerous condition if untreated that interfered with the ability to engage in the community in a safe way. The attending psychiatrist then interviewed the individual and reviewed the medical chart and collateral sources. The attending psychiatrist concluded that the individual exhibited poor judgment and potentially aggressive and violent verbal and physical behavior and as such, should be held for further observation under MHL § 9.40. Upon further interviews and observations, the individual was converted to a MHL § 9.39 status. The court found that the doctors' diagnoses, actions, and subsequent determinations under MHL §§ 9.40 and 9.39 did not fall substantially below accepted medical standards.[17]

[17] *Kraft v. City of NY*, 696 F.Supp.2d 403 (2010).

**Resources**

Office of Mental Health; Mental Hygiene Law – Admissions Process
OMH Form 471 – Application for Involuntary Admission on Medical Certification
OMH Form 471a – Certificate of Examining Physician
OMH Form 471b – Request by Examining Physician to Transport A Mentally Ill Person
OMH Form 474 – Emergency Admission

This guidance is intended to provide information about NYS statutes related to involuntary inpatient mental health treatment. Clinicians should feel comfortable contacting their local NYS OMH Field Office to discuss specific cases and circumstances in which questions arise regarding involuntary care.