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## 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.<sup>1</sup>

## 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.<sup>2</sup> One third of homeless individuals suffer from a serious mental illness; the numbers are even higher for homeless single adults.<sup>3</sup> 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.<sup>4</sup>

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<sup>1</sup> 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.

<sup>2</sup> 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/>

<sup>3</sup> 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>

<sup>4</sup> *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.<sup>5</sup>

Further cases followed and applied the same standard as found in *Boggs* and it is now well settled law<sup>6</sup> 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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<sup>5</sup> *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).

<sup>6</sup> *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<sup>7</sup> for which care and treatment as a patient in a hospital is essential to such

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<sup>7</sup> 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.<sup>8</sup> 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.<sup>9,10</sup>

The following are examples of individuals who would meet criteria for involuntary admission on medical certification<sup>11</sup>:

- 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.<sup>12</sup>
- 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.<sup>13</sup>
- 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.<sup>5</sup>
- 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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<sup>8</sup> *Matter of Harry M*, 96 A.D.2d 201, 468 N.Y.S.2d 359 (N.Y. App. Div. 1983).

<sup>9</sup> *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).

<sup>10</sup> *Matter of Seltzer v. Hogue*, 187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993).

<sup>11</sup> While these examples are derived from the cited published caselaw, some of the facts may have been altered in this guidance for narrative purposes.

<sup>12</sup> *Rueda v. Charmaine D.*, 17 N.Y.3d 522, 958 NE 2d 106, 934 N.Y.S.2d 72 (2011).

<sup>13</sup> *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.<sup>14</sup>

- 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.<sup>15</sup>
- 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.<sup>16</sup>

### **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)

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<sup>14</sup> *Matter of Paulina D.*, 104 A.D.3d 883, 961 N.Y.S.2d 320 (N.Y. App. Div. 2013).

<sup>15</sup> *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).

<sup>16</sup> *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.<sup>17</sup>

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<sup>17</sup> *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.