OMH Interpretative Guidance for Involuntary and Emergency Admissions Webinar Q&A

Legal & Interpretative Guidance Questions

Question	Answer
Where can I find the official OMH forms for emergency and involuntary holds	Forms can be found here; a helpful chart of Mental Hygiene Law admissions is here.
Has there been discussion with MHLS to make sure they are in alignment with this interpretive guidance?	The interpretative guidance memo was shared with MHLS when it was disseminated.
What is a 9.39 Hospital?	A 9.39 hospital is a hospital that has been designated by the Commissioner as capable of retaining and treating individuals pursuant to Mental Hygiene Law §9.39. Facilities include hospitals with licensed inpatient psychiatric units pursuant to 14 NYCRR §573.1.
How many days can you hold a patient under a 9.39 admission?	15 days
Our regional hospital regularly states that, in addition to a dangerousness requirement, there is a requirement that a person will "benefit" from hospitalization. Please comment.	For purposes of the emergency admission pursuant to MHL §9.39 an individual must "have a mental illness for which immediate observation, care, and treatment in a hospital is appropriate." For a 2 PC, the individual must be "in need of treatment."
Does OMH's *Interpretative Guidance for Involuntary and Emergency Admissions* pertain to the average hospital emergency department that does not have a psych unit (i.e., an average ED doc using 9.39 (1PC))?	The *Interpretive Guidance* applies to all hospitals that may lawfully receive and retain individuals pursuant to the Mental Hygiene Law. Please note that other facilities may also direct the removal of an individual to a 9.39 hospital or CPEP, including: • the director of a general hospital without a psychiatric inpatient unit upon the recommendation of an ER MD pursuant to MHL 9.57, or • a qualified psychiatrist supervising or providing treatment in an OMH licensed facility without a psychiatric inpatient unit pursuant to MHL 9.55. An individual may also be involuntarily transported to a 9.39 hospital or CPEP by a peace or police officer pursuant to MHL § 9.41 or a Director of Community Services or their designee pursuant to MHL § 9.45.
Do any of these guidelines change when you are in a non-9.39 hospital.	9.39s and 9.27s can be initiated in non-9.39 hospitals, and so the guidelines as they pertain to the initiation of such applications is relevant. There must be a confirmatory exam in a hospital that can admit the individual once the patient is transferred.
Can a hospital without a 9.39 designation retain a patient against their will pending transfer to a hospital with a CPEP or an inpatient unit?	This question cannot be addressed categorically in a Q&A format as it is fact dependent and there are legal complexities. Please confer with your hospital's leadership and legal counsel.

Question	Answer
If an emergency physician at a hospital without psychiatric services deems that a patient is unsafe (based on OMH law and guidance) and meets criteria for involuntary psychiatric admission, does the hospital security staff have the right to stop the patient from leaving the hospital and then place the patient in the appropriate restraints if needed to keep the patient safe until transport to a psychiatric facility?	This question cannot be addressed categorically in a Q&A format as it is fact dependent and there are legal complexities. Please confer with your hospital's leadership and legal counsel.
I work in a non-9.39 hospital and I was wondering what legals should be sent upon transfer to an inpatient psychiatric hospital. Would a 2PC be best or a 9.37?	A 9.37 would require an application by a DCS or DCS designee. Either 9.37 or 9.27 would be reasonable.
We had a patient that came into the ER with an overdose suicide attempt. The patient required medical treatment first in our intensive care unit for 48 hours. Can we 2 PC this patient until they are medically cleared and psych evaluated?	In a hospital that has a psychiatric inpatient unit or CPEP: The 2PC could be initiated by two licensed physicians (e.g., the ER doctor and the intensivist) while the patient is still in the ER or the ICU. A hospital psychiatrist would do a third confirmatory exam. This can happen even before the patient is transferred to the same hospital's psychiatric inpatient unit. In a hospital that does not have a psychiatric inpatient unit or CPEP: The application and two physician certificates may be completed, but the 2PC is not active until the patient is transferred to an admitting hospital where there can be a third confirmatory exam by a staff psychiatrist. Such admission must occur within ten days of the execution of the 2PC application.
Can a primary care provider issue a pickup order (9.45)	MHL §9.45 describes the authority of the Director of Community Services (DCS) (or the director's designee) to direct peace officers to transport to a 9.39 hospital or CPEP individuals reported by a parent, adult sibling, spouse or child of the individual, a legal guardian, a licensed psychologist, registered professional nurse providing treatment, intensive case manager, licensed physician, health officer or peace or police officer to have a mental illness • for which immediate care and treatment are appropriate, and • which is likely to result in serious harm to self or others
What form should an emergency physician use when sending a patient involuntarily to a CPEP? 9.57?	MHL §9.57 describes the authority of ER physicians to transfer patients to a CPEP. Please look at the form on page 13 of this compilation: https://omh.ny.gov/omhweb/forensic/manual/pdf/chptr7.pdf
Do you have any recommendations for a general hospital with no BH program for getting patients adjudged to meet these criteria over to a CPEP or inpatient program?	MHL §9.57 describes the authority of hospital directors, upon the request of ER physicians, to direct the police removal of patients to a CPEP or 9.39 program.

Question	Answer
What is a 22.09 order?	Mental Hygiene Law section 22.09 orders allow a peace officer to remove an individual who is intoxicated to the degree that there is likelihood to result in harm to self or others to an ER for evaluation. Please contact the Office of Addiction Services and Supports for more information.
How is "appears to have a mental illness" defined for a 9.41?	§9.41(a) provides as follows: "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." The phrase "appears to have a mental illness" is not statutorily defined and is therefore subject to police discretion. As was described in the referenced case examples, officers will hopefully transport individuals demonstrating erratic behavior that puts themselves or others at risk of harm to a 9.39 hospital or a CPEP. It is not the expectation that officers accurately diagnose mental illness. Providing a detailed description of the concerning behavior to the CPEP psychiatrist would be helpful in ensuring all relevant information is included in determining whether the patient meets criteria for involuntary retention pursuant to either 9.39 or 9.27.
I frequently hear doctors choosing not to admit despite dangerous history or behavior because the patient does not have a treatable mental illness, such as a personality disorder. Please comment whether treatable or not is a criterion.	Personality disorders are often challenging to diagnose and comorbid to other psychiatric disorders, SUD, or chronic medical problems. These diagnoses are not static and a person's level of risk varies with worsening of comorbid illness and other psychosocial and environmental factors. Also, while personality disorders are generally not optimally treated in inpatient settings, an inpatient admission may be necessary when an individual with a personality disorder is experiencing a crisis that cannot be safely managed in the community. The inpatient admission may also be helpful to connect the individual to appropriate care management and ambulatory treatment that can treat underlying personality pathology.
Can you clarify the "mental illness" clause of emergency admissions? There is a misconception that patients with illnesses that are not treatable psychiatric illnesses (dementia) should be admitted	MHL § 9.39 provides that an individual must "have a mental illness for which immediate observation, care, and treatment in a hospital is appropriate." Dementia is not a mental illness for the purposes of any Article 9 admission standard. However, there may be comorbid conditions that are.
Does dementia without a specific psychiatric diagnosis qualify as a "mental condition" under the Mental Hygiene Law	Dementia does not quality as a mental illness, as such term is defined in MHL §1.03.
Will you share the cases that help define "imminent risk to harm to self or others"	Please see the February 2022 *Interpretative Guidance* memo.

Implementation Questions

Question	Answer
In terms of reimbursement, are payors "on board" with these admissions?	Managed Care plans regulated by NYS are required to consider both acute presentation and underlying conditions when making medical necessity determinations.
Will insurance companies reimburse if a patient is not imminently at risk?	Managed Care plans regulated by NYS are required to consider both acute presentation and underlying conditions when making medical necessity determinations. If hospitals experience denials by NYS regulated Managed Care plans for individuals admitted on emergency or involuntary holds, please contact the OMH Parity Mailbox: OMH.Parity@omh.ny.gov.
How do we reconcile the broader definition of dangerousness based on landmark cases which are preceding deinstitutionalization era, pre-ACT/pre-AOT era, with modern day QI indicators like length of stay and shrinking inpatient beds availability?	The legal definition of dangerousness established by the MHL and clarified in the cases cited in the presentation is the standard that the field should use when determining if an individual meets criteria for involuntary retention.
It is noble to broaden the interpretation of involuntary criteria but unless there is improved bed availability, I think it will be difficult to implement in some communities.	The criteria for emergency and involuntary admission is not broadened. This is a clarification of the existing legal standard.