

**PROTECTION OF PEOPLE WITH SPECIAL NEEDS ACT (PPSNA)
OFFICE OF MENTAL HEALTH
FAQ
June 12, 2013**

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OMH FREQUENTLY ASKED QUESTIONS:

1. What is the purpose of the PPSNA?

The PPSNA (Chapter 501 of the Laws of 2012) created the Justice Center for the Protection of People with Special Needs ("Justice Center") a new State agency that will track and prevent, as well as investigate and prosecute, reports of abuse and neglect of persons with disabilities or special needs (i.e., "vulnerable persons"). The purpose of the PPSNA is to create a set of consistent safeguards for vulnerable persons served by systems under the jurisdiction of 6 State agencies to protect them against abuse, neglect, and other dangerous conduct, to aggressively investigate and address instances of neglect and abuse, and to provide fair treatment to employees upon whom vulnerable persons depend for their care. Among its provisions, the PPSNA:

- Creates the Justice Center and the Vulnerable Persons Central Register;
- Creates standard definitions of abuse and neglect
- Identifies" mandated reporters" who are required to report abuse and neglect and significant incidents to the Justice Center;
- Implements proportional and progressive discipline for acts of abuse or neglect of vulnerable persons; and
- Consolidates criminal history background check functions

2. Does the Justice Center replace the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQCAPD), the State agency that already has oversight authority with respect to the care of persons served by mental hygiene agencies?

The Justice Center will absorb all functions and responsibilities of the CQCAPD, with the exception of the Federal Protection and Advocacy and Client Assistance Programs which will be conducted by Disability Rights New York (formerly Disability Advocates, Inc.), an independent entity designated by Governor Cuomo.

3. The protections of the PPSNA apply to "vulnerable persons." Who is a "vulnerable person?"

A "vulnerable person" is an individual who is receiving care in a facility, provider agency, or program that is:

- operated, certified, or licensed by the Office for People with Developmental Disabilities (OPWDD),
- operated, certified, or licensed by the Office of Mental Health (OMH), (*excluding* the Sex Offender Management Program or programs located within correctional institutions);
- operated, certified, or licensed by the Office of Alcoholism and Substance Abuse Services (OASAS);

- operated by the Office of Children and Family Services (OCFS) for juvenile delinquents or juvenile offenders, and residential programs or facilities licensed by OCFS, (*excluding* foster family homes and residential programs for victims of domestic violence);
- licensed by the Department of Health (DOH) as an adult home that has over 80 beds, and where at least 25% of residents are persons with mental illness;
- an overnight summer day and traveling summer day camp for children with developmental disabilities under the jurisdiction of DOH;
- the NYS School for the Blind and the NYS School for the Deaf, and institutions with residential components, special act school districts serving students with disabilities, or in-state, residential special education, under the jurisdiction of the State Education Department (SED).

4. What types of provider agencies are responsible for complying with the PPSNA?

The authority of the Justice Center extends over certain facilities and provider agencies that are operated, certified, or licensed by the following State agencies:

- Office of Mental Health (OMH)
- Department of Health (DOH),
- Office for People with Developmental Disabilities (OPWDD),
- Office of Children and Family Services (OCFS),
- Office of Alcoholism and Substance Abuse Services (OASAS),
- State Education Department (SED)

5. Do all providers under the jurisdiction of OMH have to comply with the PPSNA?

The PPSNA is a comprehensive law that consists of 8 distinct Parts. While providers of mental health services licensed, directly operated, or funded by OMH are *generally* subject to all of the provisions of the PPSNA, certain Parts of the PPSNA contain some limited exceptions. For example:

- All incidents, including allegations of abuse and neglect, that occur in Article 10 secure treatment facilities for sex offenders, or in satellite outpatient clinics located in correctional institutions, will continue to be reported to and investigated by OMH, rather than the Justice Center;
- Article 28 general hospitals remain exempt from the criminal history record check process required for providers of mental health services. The exemption covers mental health services that are included as part of the hospital's Article 28 operating certificate, even if the provider of these services also holds an Article 31 license issued by OMH. These include a psychiatric inpatient unit of an Article 28 hospital and any outpatient mental health clinics that are included within the Article 28 license.

6. Are adult homes responsible for compliance with the PPSNA?

Some are. The protections of the PPNA extend to adult homes and enriched housing programs:

- that are licensed by DOH;
- that have a licensed capacity of more than 80 beds;
- in which at least 25% of the residents have a serious mental illness (as defined in the Mental Hygiene Law); and;
- which are *not* authorized to operate 55% or more of their total licensed capacity of beds as assisted living program beds.

7. What is the Code of Conduct?

Under the PPSNA, all individuals working with vulnerable persons must be made aware of their obligations to assist such persons to lead safe, vital and productive lives. The law requires the Justice Center to develop a code of conduct for custodians... This code of conduct is intended to serve as a code of basic ethical standards. It must be read and signed by all custodians who provide services to vulnerable persons at the time of employment, and at least annually thereafter.

OMH has distributed the Code to providers under OMH's jurisdiction that must comply with the PPSNA. OMH will require that each custodian read and sign this attestation and that it be placed in personnel files. Personnel files will be checked for this document in future licensing visits.

8. Who must sign the Code of Conduct?

The Code of Conduct must be signed by custodians who provide services to vulnerable persons in facilities that must comply with Section 488 of the Social Services Law. This includes mental health providers operated or licensed by OMH, *with the exception* of Article 10 secure treatment facilities for sex offenders, and satellite outpatient clinics located in correctional institutions,

Nonetheless, with respect to distributing the Code of Conduct and Mandated Reporter guidance, employees who work in the excluded facilities will be provided with a copy of the Code of Conduct and Mandated Reporter guidance on an informational basis. However, these employees are NOT required to sign either document.

It should be noted that custodians who are required to sign the Code and refuse to do so may be subject to disciplinary action.

9. What is the Vulnerable Persons Central Register (VPCR)?

The Vulnerable Persons' Central Register (VPCR) is a statewide database maintained by the Justice Center to perform necessary functions related to the receipt and acceptance of reportable incidents involving vulnerable persons and the investigation of these

incidents. The VPCR will receive incident reports through a 24/7 call center housed at the Justice Center. Effective June 30, 2013, mandated reporters at OMH operated and licensed providers are required to contact the VPCR at 1-855-373-2122 when they discover that a reportable incident has occurred."

10. What is a "Custodian?"

The term "custodian" is used in the PPSNA to refer to those who have a legal obligation to protect vulnerable persons from harm while they are under their care. The following are "custodians:" a director, operator, employee or volunteer of a provider that serves vulnerable persons (*see FAQ #3*) or a consultant or contractor with such a provider that has regular and substantial contact with persons served by the provider.

11. What is a "Mandated Reporter?"

A Mandated Reporter is someone who is required by the PPSNA to report suspected abuse and neglect of vulnerable persons, as well as "significant incidents," to the VPCR immediately upon discovery *All custodians are mandated reporters, as well as the following human service professionals:*

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| * Physician | * Licensed practical nurse | * Licensed occupational therapist | * Hospital personnel engaged in the admission, examination, care, or treatment of persons |
| * Registered physician's assistant | * Nurse practitioner | | |
| * Surgeon | * Social worker | | |
| * Medical examiner | * Emergency medical technician | | * Christian Science practitioner |
| * Coroner | * Licensed creative arts therapist | | * School official, including (but not limited to): |
| * Dentist | * Licensed marriage and family therapist | | - school teacher |
| * Dental hygienist | * Licensed mental health counselor | | - school guidance counselor |
| * Osteopath | * Licensed psychoanalyst | | - school psychologist |
| * Optometrist | * Licensed speech/language pathologist/audiologist | | - school social worker |
| * Chiropractor | * Licensed physical therapist | | - school nurse |
| * Podiatrist | | | - school administrator or other school personnel required to hold a teaching or administrative license or certificate |
| * Resident | | | |
| * Intern | | | * Social services worker |
| * Psychologist | | | |
| * Registered nurse | | | |

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| * Any child care or foster care worker | by the NYS Office of Alcoholism and Substance Abuse Services | * District attorney or assistant district attorney | office of the district attorney |
| * Mental health Professional | * Peace officer | * Investigator | * Any other law enforcement official |
| * All persons credentialed | * Police officer | employed in the | |

12. If a mandated reporter does not make a report as required by the PPSNA, is s/he subject to any penalty?

Mandated reporters who are human service professionals who fail to report under the PPSNA could be charged with a Class A misdemeanor and subject to criminal penalties. Custodians who fail to report are subject to disciplinary penalties. Further, all mandated reporters can be sued in a civil court for monetary damages for any harm caused by the mandated reporter's failure to make a report to the VPCR.

13. How does a mandated reporter make a report to the VPCR?

Upon discovery of an allegation of abuse or neglect, or a significant incident, a mandated reporter must report by telephone or the internet (if the mandated reporter works for a provider covered by the PPSNA) to the VPCR. The VPCR is open 24 hours a day, seven days a week, to receive reports.

14. What if multiple mandated reporters witness the same event?

The current expectation of the Justice Center is that all mandated reporters are required to report the event.

15. Is a mandated reporter under the PPSNA the same thing as a mandated reporter who must report child abuse to the Statewide Register for Child Abuse and Maltreatment (SCR)? Will the SCR continue to exist after June 30, 2013?

Although many of the human services professionals that are considered mandated reporters to the VPCR are the same as those that must report to the SCR, the lists are not the same. However, after June 30, 2013, reports of child abuse in institutional settings (e.g., providers of inpatient or residential mental health services operated or licensed by OMH) will no longer be made to the SCR. Instead, allegations of abuse and neglect of children in institutional settings must be made to the VPCR, and investigations will be conducted by the Justice Center. Mental Health providers and their staff remain bound to comply with NYS Social Services Law Section 413 and the requirements of the NYS Office of Children and Family Services (OCFS) regarding mandatory reporting of the abuse and neglect of children by a parent or caretaker or foster family boarding home setting – these reports will continue to be made to the SCR.

16. What are mandated reporters’ responsibilities regarding the reporting of crimes?

While crimes perpetrated against vulnerable persons by custodians are a reportable incident that must be reported by a mandated reporter to the VPCR, it is also important to remember the OMH licensed are separately required to make a report to law enforcement if it appears that a crime may have been committed, by any person, against a person receiving services from that provider under Section 31.11 of the Mental Hygiene Law. This law must also be followed. Furthermore, the PPSNA does not prevent a mandated reporter from directly contacting law enforcement or emergency services, either before or after making a report to the VPCR.

17. What is abuse?

It is a core obligation of every provider covered by the PPSNA to protect the persons they serve from harm “Abuse” occurs when a vulnerable person is harmed, or is placed at risk of harm *because of an act of a custodian*. The term “abuse” includes physical abuse, psychological abuse, sexual abuse, and deliberate inappropriate use of restraint. The table below includes a summary of the definition of each type of abuse, and provides some examples of conduct that would fit these definitions

Category	PPSNA Definition	Examples
Physical Abuse	Conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or causing the likelihood of such injury or impairment. Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any person.	Hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, the use of corporal punishment. .
Psychological Abuse	Conduct by a custodian intentionally or recklessly causing, by verbal or nonverbal conduct, a substantial diminution of a service recipient’s emotional, social or behavioral development or condition, supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor, or causing the likelihood of such diminution.	Intimidation, teasing, taunting, name calling, threats, displaying a weapon or other object that could reasonably be perceived by the vulnerable person as a means of infliction of pain or injury, insulting or coarse language or gestures directed toward a patient which subjects the patient to humiliation or degradation; derogatory comments or ridicule, violation of patient rights or misuse of authority.
Sexual	Conduct by a custodian that	Rape, sexual assault,

Abuse	subjects a person receiving services to any offense defined in article one hundred thirty or section 255.25, 255.26 or 255.27 of the penal law; or any conduct or communication by such custodian that allows, permits, uses or encourages a service recipient to engage in any act described in articles two hundred thirty or two hundred sixty-three of the penal law.	inappropriate touching or fondling, indecent exposure, penetration (or attempted penetration) of vagina, anus or mouth by penis, fingers, or other objects, any sexual activity involving a vulnerable person that is allowed or encouraged by a custodian, taking or distributing sexually explicit pictures, voyeurism, or sexual exploitation.
Deliberate Inappropriate Use of Restraint	Not defined	Using restraint as punishment, for the convenience of staff, or with deliberate cruelty.

18. What is neglect?

“Neglect” means that a vulnerable person has been harmed, or is placed at risk of harm, because of a failure by a custodian to exercise his or her duty to care for the vulnerable person by:

- failing to provide supervision;
- failing to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care; or
- failing to provide access to educational instruction where there is a duty a duty to ensure that the vulnerable person obtain such instruction.

19. What is a “significant incident?”

In addition to allegations of abuse or neglect, the PPSNA also requires mandated reporters to report “significant incidents” to the VPCR. A “significant incident” is an event that, because of its severity or the sensitivity of the situation, may result in harm to the health, safety or welfare of a vulnerable person. This is a broad group of adverse events, some which may involve acts of custodians, such providing care in an unskillful or unauthorized manner, but they may also include acts of other vulnerable persons, such as assaults. Revised OMH incident management regulations identify “significant incidents” in the OMH system, which must be reported both to the Justice Center through the VPCR and to OMH.

20. What is a “reportable incident?”

Under the PPSNA, “reportable incidents” include allegations of abuse and neglect, and significant incidents. Reportable Incidents” must be reported to the Justice Center via the VPCR.

21. How did the PPSNA change the criminal history background check requirements that OMH providers must currently follow?

The PPSNA centralized, within the Justice Center, the criminal background check process for facilities or providers overseen by the Office of Mental Health (OMH), the Office for People with Developmental Disabilities and the Office of Children and Family Services (OCFS) within the Justice Center. Effective June 30, 2013, providers that previously submitted requests to OMH for criminal history background checks will instead submit these requests to the Justice Center, which has assumed full responsibility for the process.

22. Will the PPNSA result in any changes to the way that criminal history record checks are processed?

For OMH providers, there should only be minimal procedural change to the current criminal background check process, which was established back in 2005. Providers of services, including those that are licensed, who contract with or who are otherwise approved by OMH will still have to request a criminal background check be conducted for each prospective employee or volunteer who will have regular and substantial unsupervised or unrestricted contact with the providers' clients. Current exemptions from this requirement (e.g., Article 28 providers) will be maintained. Prospective “natural person” operators seeking licenses to provide services are still required to have a criminal background check.

Consistent with the current process, the providers' Authorized Persons will be empowered to request, receive, and review criminal history information. Providers must still obtain the consent of prospective employees or volunteers who will have regular, unsupervised client contact to having their fingerprints taken and a criminal history check performed. The fingerprints will still be taken by an OMH designated fingerprinting entity and will be submitted to the New York State Division of Criminal Justice Services (DCJS). After June 30, 2013, DCJS will provide criminal history information responses to the Justice Center instead of OMH.

When a provider requests a fingerprint check and DCJS sends the results to the Justice Center, the Justice Center will review the information and advise the provider whether or not the applicant has a criminal history, and, if so, whether the criminal history is of such a nature that the person cannot be hired or retained. In some cases, a person may have a criminal background that does not rise to the level that would preclude being hired or retained. Although the criminal history "rap sheet" cannot legally be shared with the provider, providers will continue to receive determination letters that will include a summary of the New York State criminal history record. However, a summary of criminal history information obtained from the FBI nationwide criminal history record search will no longer be included. The Justice Center has been advised by DCJS that the FBI has recently directed that the results of its nationwide criminal history record search may not be re-disclosed to private, non-governmental agency providers. As such, letters will indicate that any reported information is limited to New York State criminal history information, and that no

information regarding the existence (or lack thereof) or content of out-of-state criminal history information is being disclosed.

The Justice Center recognizes that these changes to OMH's longstanding process may cause some initial concern. However, consistent with current practice, the Justice Center Criminal Background Check legal staff will continue to review the applicant's entire criminal history record and render its employment suitability determinations in accordance with Article 23-A of the Correction Law.

For mental health providers, OMH will remain responsible for monitoring compliance with the criminal history background check requirements. Finally, the fees associated with criminal history background checks will continue to be the responsibility of the State.

23. What about OMH funded providers? Must they still obtain criminal history background checks?

Yes.

24. Are Article 28 hospitals still exempt from requesting criminal history background checks for applicants for positions that will have regular and substantial contact with persons receiving mental health services?

Yes Article 28 hospitals, as defined in the Public Health Law, remain exempt from the criminal history record check process. The exemption covers providers that are included as part of the hospital's Article 28 operating certificate, even if they also hold an Article 31 license issued by OMH. These include a psychiatric inpatient unit of an Article 28 hospital and any outpatient mental health clinics that are within the Article 28 license, including:

- outpatient clinics located on the hospital campus;
- extension clinics which are a component of a general hospital sponsored ambulatory care program, or a diagnostic and treatment center sponsored ambulatory care program, offering services of a non-emergent nature and located on premises other than those of the hospital or diagnostic and treatment center which operates it; and
- part-time clinic sites that are ambulatory care program sites operating less than 60 hours per month by a general hospital or a diagnostic or treatment center which is approved to operate part-time clinics.

However, mental health clinics and community residences operated by Article 28 hospitals but which are not included within the Article 28 operating certificate are not exempt from the criminal history background check requirements.

25 Currently, State operated facilities are exempt from the Mental Hygiene Law Section 31.35 criminal history background check process, but criminal histories are obtained and reviewed under a different law. Will that process change?

The Justice Center will receive requests for criminal histories for persons applying to work in State operated facilities. However, for state facilities, criminal history information will be forwarded by the Justice Center to the facility's "Authorized Person" for their use in making a suitability determination, based on the standards contained in Article 23-A of the Correction Law. The hiring decision will be made by OMH.

26. What about OASAS? Will the Justice Center review criminal histories of applicants for positions in facilities under OASAS' jurisdiction?

No. The PPSNA did establish a criminal history background check process for programs under the jurisdiction of OASAS, but that process is the responsibility of OASAS, not the Justice Center. Requests for reviews of applicants for positions in facilities under OASAS' jurisdiction must be made directly to OASAS.

27. What is the Staff Exclusion List? (SEL)

Similar in concept to the Statewide Register for Child Abuse and Maltreatment, the VPCR will generate a Staff Exclusion List (SEL), which will contain the names of individuals found responsible for egregious (Category One) or repeated (Category Two) acts of abuse or neglect of vulnerable persons. Before being placed on the SEL a person will have the right to challenge that finding. However, once listed on the SEL, a person will be forever barred from future employment in the care of vulnerable persons.

Employees who are found responsible for less serious acts will receive progressive discipline, including retraining and other actions necessary to facilitate their safe return to the workplace.

28. Who is required to do a Staff Exclusion List (SEL) check?

In the mental health system, the SEL check must be requested by any facility or program that is operated or licensed by OMH.

29. What about funded providers? Are they required to do a Staff Exclusion List (SEL) check?

Yes. Mental health providers funded by OMH must also request an SEL check. However, if an applicant's name is included in the SEL, it is within the discretion of the funded provider whether or not to hire or allow the applicant to have regular and substantial contact with a vulnerable person.

30. If a provider is required to request a criminal history background check, does the provider still have to request a Staff Exclusion List (SEL) check?

Yes. In fact, the SEL check must be requested *first*. The PPSNA *requires that the SEL check be made prior to requesting a criminal background check*. Mental health providers licensed or operated by OMH must, through their Authorized Person (i.e., the individual designated with authority to request and receive criminal history background check information) first submit a request to the Justice Center for a review of the SEL. If the applicant in question is listed on the SEL as having committed a Category 1 or 2 offenses, that person cannot be hired. Thus, the provider will not need to submit a criminal history background check request and the application process must be terminated at that point. However, if the result of the SEL check does not prohibit an applicant from being hired, the mental health can request a criminal history background check through the Justice Center.

31. If a provider is exempt from the criminal history background check requirement (e.g., an Article 28 provider), is that provider also exempt from the requirement to check the Staff Exclusion List (SEL)?

No if a provider is operated or licensed by OMH, the SEL check is required.

32. Are providers of mental health services required to check current staff against the Staff Exclusion List (SEL)?

No, facilities and provider agencies are only required to check staff that are hired or retained after June 30, 2013.

33. Will a fee be imposed to check the Staff Exclusion List (SEL)?

No. There are no costs associated with requesting an SEL check. .

34. Why was it necessary to change OMH incident reporting regulations (14 NYCRR Part 524?)

The PPSNA charged the Justice Center with recommending policies and procedures to OMH for the protection of persons with mental illness. This effort involves the development of requirements and guidelines in areas including but not limited to incident management, rights of people receiving services, criminal background checks, and training of custodians. In accordance with the PPSNA, these requirements and guidelines must be reflected, wherever appropriate, in OMH's regulations. Consequently, OMH has drafted revisions to Part 524 to incorporate the requirements in regulations and guidelines recently developed by the Justice Center.

The amendments make changes related to definitions, reporting, investigation, notification, and committee review of events and situations that occur in providers of mental health services licensed or operated by OMH. It is OMH's expectation that

implementation of the proposed amendments will enhance safeguards for persons with mental illness, which will in turn allow individuals to focus on their recovery.

35. Under the revised regulations, what incidents are included as “Reportable Incidents?”

For OMH licensed and operated providers, the majority of incidents that are currently reportable to OMH under existing criteria were determined to meet the PPSNA criteria for “Reportable Incidents.” In addition, the PPSNA listed several adverse events not currently reported under 14 NYCRR Part 524, which had to be added. The revised regulations therefore require that incidents of the following constitute “Reportable Incidents, (i.e., allegations of abuse/ neglect and significant incidents) which must be reported to **both** the Justice Center and to OMH:

- *Allegations of Abuse or Neglect;*
- *Assault* which results in serious injury or harm (i.e., or Harm Level 2 or 3);
- *Choking*
- *Crime*, which occurs on program premises or when a patient is under the intended supervision of staff, and which involves a patient as the victim or which affects or has the potential to affect the health or safety of one or more patients of the program or has the potential to have a significant adverse impact on the property or operation of the program. (Serious violent crimes involving patients that take place in the community, such as homicide, homicide attempt, and assault, will continue to be reported to OMH).
- *Death of a patient;* (if the death is considered “suspicious”)
- *Falls by patients*, resulting in serious injury (i.e., Risk or Harm Level 2 or 3);
- *Fights*, which result in serious harm to a patient (i. e, Risk or Harm Level 2 or 3)
- *Fire setting;*
- *Injury;*
- *Injury of unknown origin*
- *Missing patient*
- *Mistreatment*
- *Obstruction of reports of Reportable Incidents;*
- *Other Incident:* An event, other than one identified in this subdivision, which has or creates a risk of, an adverse effect on the life, health, or safety of a patient;
- *Self abuse;* that results in serious harm to a patient; (i.e., Risk or Harm Level 2 or 3)
- *Severe adverse drug reaction;*
- *Sexual contact between children;*

- *Sexual assault;*
- *Suicide attempt;*
- *Unlawful use or administration of controlled substance; and*
- *Verbal aggression by Patients.*

36. What incidents must OMH providers report now, which were not required to be reported under current 14 NYCRR Part 524?

The following “new” incidents must be reported under the revisions to 14 NYCRR Part 524:

- *Choking* a choking event experienced by a patient as a result of ingestion of food or other foreign object, resulting in life threatening harm or admission to a hospital, and there is a written directive for such patient concerning risk of choking in place at the time of the event.
- *Obstruction of reports of Reportable Incidents:* conduct by a custodian that impedes the discovery, reporting or investigation of the treatment of the patient by falsifying records related to the safety, treatment or supervision of a patient, actively persuading a Mandated Reporter from making a report of a reportable incident to the Statewide Vulnerable Persons Central Register with the intent to suppress the reporting or the investigation of an incident, intentionally making a false statement or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report, or failure by a Mandated Reporter to report a reportable incident upon discovery.
- *Unlawful use or administration of a controlled substance:* any administration by an employee of a controlled substance, as defined by Article 33 of the Public Health Law without a lawful prescription, or other medication not approved for any use by the federal Food and Drug Administration, and/or unlawful use or distribution by an employee of a controlled substance as defined by Article 33 of the Public Health Law at the workplace or while on duty.

37. There are some incidents on the list of “Reportable Incidents” that do not look familiar under current regulations or NIMRS, but they are not included in the list of “new” events in Q #36. Please explain.

Some of the revisions to Part 524 are intended to conform criteria for Reportable Incidents under the PPSNA to existing reporting requirements under current Part 524. To do this, some events have been categorized and identified differently in the revised regulations. Therefore, a certain event that currently must be reported to OMH may be identified by a different category going forward. OMH anticipates development of a crosswalk to assist providers as they adjust to these new categories. These events include:

- *Mistreatment:*,
 - (1) use of restraint that is inappropriate because it was implemented without a valid physician’s order or in a manner that was otherwise not compliant with applicable state or federal regulations, but which does not rise to the level of physical abuse, as defined in this section;
 - (2) use of seclusion that was unauthorized because it was implemented without a valid physician’s order or in a manner that was otherwise not compliant with applicable state or federal regulations;
 - (3) use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming;
 - (4) a medication event, including:
 - (i) a medication error, or a failure to properly supervise a patient in the self-administration of a drug, that creates a risk of, or results in, serious temporary or permanent harm to the patient; or
 - (ii) any intentional administration to a patient of a prescription drug or over-the-counter medication which is not in substantial compliance with a physician's, dentist's, physician's assistant's, specialist’s assistant’s, or nurse practitioner's prescription
 - (5) use, appropriation, or misappropriation by a custodian of a patient’s resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources. Examples include the deliberate misplacement, theft, or wrongful, temporary, or permanent use of a patient’s belongings or money...

- *Verbal Aggression by Patients:* a sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious harm.

38 In Q#17, “restraint” is identified as abuse. However, in Q #37, it is also included as “mistreatment.” What is the difference?

Restraint or seclusion that is implemented consistent with applicable laws and regulations is neither abuse nor mistreatment. However, if restraint is “deliberate and inappropriate,” i.e., it is done for the purpose of punishment or the convenience of staff, or with deliberate cruelty, it is abuse. An example of what would be “deliberate cruelty” would be purposely using a restraint device or technique that was specifically prohibited in an individual’s crisis prevention plan, or use of excessive force in implementing a restraint.

If restraint or seclusion is not implemented consistent with applicable laws and regulations (such as without a physician’s order) but does not rise to the level of being “deliberate and inappropriate: it must be reported as mistreatment.

If the use of restraint constitutes abuse, the person who engaged in that activity could be placed on the SEL. A finding of mistreatment, though subject to disciplinary penalties, would not result in inclusion on the SEL.

39. How can “time out” be considered “mistreatment?”

Part of the challenge in standardizing definitions across different human services systems is that the same terms are sometimes used to mean completely different things. In the OMH system, “time out” means a voluntary procedure used to assist a patient in regaining emotional control. In order for an intervention to be considered time out, the patient must be permitted to enter and exit the area or room completely voluntarily.

However, in other systems, (such as the OPWDD system), it is a different type of intervention that requires prior authorization. The PPSNA includes, as a significant incident, the use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming. Therefore, although it must be included in the list of Reportable Incidents in OMH regulations, it is unlikely that it will ever occur.

40. There are some incidents mental health providers must identify and monitor now that are not included as Reportable Incidents. Is it no longer necessary to review those?

The revisions to Part 524 also include a list of incidents that are identified as "Reviewable" Incidents. These incidents are not required to be externally reported to the Justice Center or Office, but which must be internally reviewed and monitored. They include:

- *Assault* if: there is no resultant harm that requires medical intervention or treatment beyond first aid
- *Contraband*
- *Crime*, if not otherwise required to be reported to the Justice Center or OMH, but which involves a patient and which affects or has the potential to affect the health or safety of the patient. Examples include misdemeanors that occur in the community, or crimes committed by patients that occur on program premises but which do not result in, or create a risk of, harm to the patient
- *Falls by Patients*, that occur on the premises of inpatient or residential settings and which do not result in injury requiring medical treatment or intervention beyond first aid;
- *Fights* which do not result in injury requiring medical intervention or treatment beyond first aid;
- *Medication errors* that do not create a risk of, or result in, serious temporary or permanent harm to a patient
- *Self-abuse*, that does not require medical intervention or treatment beyond first aid;
- *Sexual activity between children:*

- *Sexual contact between adults*
- *Inappropriate sexual behavior.*

41. Patient death appears to only be a Reportable Incident if it is “suspicious.” What does that mean? Doesn’t this greatly restrict the reports related to death that previously had to be made, not only to OMH but to CQCAPD?

While the only type of patient death that is considered a “Reportable Incident,” necessitating a report to the VPCR, is a “suspicious” death, the revised regulations maintain the need to report other types of patient death in different ways, to achieve consistency with the PPSNA. As a result, all patient deaths that are reported now under current Part 524 will still be reported, although perhaps in a different way, under the revised Part 524.

A death is considered “suspicious, and thus a Reportable Incident that must be reported to the Justice Center via the VPCR and OMH if it involves the death of a patient of a State operated or licensed mental health provider who was enrolled in or receiving services from the facility or program at the time of the death, and the death:

- was the result of a Reportable Incident;
- resulted from an apparent homicide, suicide, or unexplained or accidental cause;
- was unrelated to the natural course of illness or disease; or
- was related to the lack of treatment provided in accordance with generally accepted medical standards.

However, consistent with the PPNSA, the regulations also provide that the Justice Center and its Medical Review Board (not the VPCR) must be notified immediately of the death of a patient of a State operated or licensed mental health provider who was enrolled in or receiving services from the facility or program at the time of the death, or whose death occurred within 30 days of discharge from a mental health program, in the form and format prescribed by the Justice Center, with an autopsy report, if available. These reports are similar to the reports of death previously made to the Medical Review Board of CQCAPD

Finally, the revised regulations require State operated or licensed mental health providers to notify OMH of the death of a patient who was enrolled in or receiving services from the facility or program at the time of the death, or whose death occurred within 30 days of discharge from a mental health program, if the patient was under the age of 18 or if the death was associated with the use or attempted use of restraint or seclusion..

42. Are there any changes to the incident reporting and investigation process under the revised regulations?

The regulations reflect some changes to the investigation process as a result of the PPSNA. Perhaps the most notable change is that allegations of abuse and neglect, as well as significant incidents, may be investigated by the Justice Center. The Justice Center

has authority to delegate responsibility for investigations to OMH, in which case OMH will conduct the investigation. OMH has the authority to delegate responsibility for investigating significant incidents to the provider of mental health services. All investigations must be conducted within 60 days of the report of the incident.

43. Providers are accustomed to reporting incidents to OMH via the New York Incident Management and Reporting System (NIMRS). Will that system no longer be used?

OMH will continue to operate NIMRS, the current incident management and reporting system. The Justice Center will be notified of reportable incidents (i.e., allegations of abuse or neglect or significant incidents) by either a phone call or a web based form. All accepted reportable incidents will be entered into the VPCR by the Justice Center. A file has been developed which will permit information exchange between the VPCR and NIMRS currently in use by mental health providers.

When a significant incident is loaded into the VPCR, the information will be downloaded into NIMRS. Any information that is obtained through the course of the investigation will be fed through NIMRS back into the VPCR. Employees working for OMH licensed providers will not have direct access to the VPCR. OMH staff will monitor completeness of alleged abuse or neglect investigations and will ensure that documentation passes between providers and the VPCR.

44. Have there been any changes to the structure or function of Incident Review Committees?

Yes. While the requirement for mental health providers to have a standing Incident Review Committee is not new, the PPSNA does contain specific requirements with regard to the composition of those Committees. These changes are reflected in the revised regulations. Committee membership must at least include:

- members of the governing body of the mental health provider; and
- persons identified by the director of such provider, including some members of direct support staff, licensed health care practitioners; service recipients; and representatives of family, consumer, and other advocacy organizations

Furthermore, the director of the mental health provider cannot be a member of the Incident Review Committee. While it is OMH's expectation that all providers will meet these requirements, in the event a provider is having difficulty revising its Committee composition, despite good faith efforts to do so, the provider should make this situation known to the Field Office. While the requirement cannot be waived, OMH will explore the circumstances with the provider to develop a strategy for achieving compliance.

For State operated providers, OMH intends to revise its governing body policy to facilitate compliance.

