NEW YORK STATE | Office of Mental Health

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Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions
Updated August 2025 (Supersedes February 2022 and July 2025 Versions)

On May 9, 2025, the Mental Hygiene Law was amended to clarify that an individual's inability to meet essential needs (food, shelter, medical care, etc.) may constitute a 'likelihood to result in serious harm.'

While this standard has previously appeared in case law and clinical practice, the amendments, effective August 7, 2025, expressly expand the statute to codify this involuntary admission criteria.

This guidance outlines the recent statutory amendments, reinforces established standards, and promotes consistent use of the "basic needs" criteria in practice.

Summary

Under Article 9 of the Mental Hygiene Law (MHL), peace officers, police officers, directors of community services, and qualified clinicians on approved mobile crisis teams are authorized to facilitate removal when an individual appears to be mentally ill and is conducting themselves in a manner likely to result in serious harm. This includes individuals who, due to their mental illness, are unable to meet basic living needs such as food, shelter, or medical care—even when there is no recent act of violence or self-harm. 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 treatment and recovery.

With recent amendments to the MHL taking effect August 7, 2025, the New York State Office of Mental Health (OMH) issues this guidance to outline the statutory grounds for removal and admission, ensure conformity with longstanding case law, and promote consistent application of the "basic needs" standard. Summaries of relevant statutes and court decisions are included below [1].

Likelihood to Result in Serious Harm

On May 9th, 2025, the MHL was amended to clarify the definition of "likelihood to result in serious harm" or "likely to result in serious harm (effective August 7, 2025)." It means:

1. substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to themselves, or
2. a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm, or
3. a substantial risk of physical harm to the person due to an inability or refusal, as a result of their mental illness, to provide for their own essential needs such as food, clothing, necessary medical care, personal safety, or shelter.

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

[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.

is likely to result in serious harm to self or others. These statutes are more fully explained below.

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.

While the May 2025 changes to Mental Hygiene Law significantly clarifies involuntary removal and hospitalization criteria, it may be helpful to review the case law that preceded the May 2025 change.

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[2].

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's behavior is likely to result in harm, but also that likelihood to result in harm is not solely determined based upon whether an individual is expressing suicidal or homicidal ideation[3]. 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."

The Appellate Division's First Department's decision 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. 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. Boggs 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[4].

Further cases followed and applied the same standard as found in *Boggs* and it is now well settled law[5] 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. Boggs and these decisions are now clearly incorporated into the text of the statute by the May 2025 changes.

I. *Primary Mechanisms for Removal from the Community*

MHL §§9.41, 9.45 and 9.58provide the authority to remove and hospitalize people who appear to have

[2] *Matter of Scopes v. Shah,* 59 A.D.2d 203, 398 N.Y.S.2d 911 (N.Y. App. Div. 1977)
[3] *Matter of Harry M*, 96 A.D.2d 201, 468 N.Y.S.2d 359 (N.Y. App. Div. 1983).
[4] *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).
[5] *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).

mental illness which is likely to result in serious harm (as defined above), with evidence of a recent overt dangerous act not being necessary.

MHL §9.41

Any law enforcement officer may take into custody any person who appears to be mentally ill and is conducting themself in a manner which is likely to result in serious harm to the person or others, as defined above.

This includes inability or refusal, due to mental illness, to provide for their own needs such as food, clothing, necessary medical care, personal safety, or shelter, as described in MHL § 9.01(c)(3).

The officer may remove the person to any hospital that operates an inpatient psychiatric service or a comprehensive psychiatric emergency program (CPEP). If immediate transport to such a facility is not feasible, the officer may temporarily detain the person in another safe and comfortable location pending examination or admission. In such cases, the officer must immediately notify the Director of Community Services or, if none is available, the local health officer.

When a law enforcement officer directs the removal of a person based on the “inability to meet their own needs” standard—i.e., where the individual appears to be mentally ill and is conducting themself in a manner likely to result in serious harm, as defined in MHL § 9.01(c)(3)—the officer must, if practicable, request that emergency medical services (EMS) conduct the transport.

Whether EMS transport is practicable is a fact-specific determination based on

- The person’s potential medical needs
- The capacity limits of local EMS agencies, as determined by those agencies
- The safety of the person, as determined by the officer

If EMS is not available or practicable under these considerations, transport may proceed using other appropriate means.

Agencies are encouraged to establish local protocols with EMS providers to help implement this provision in a manner consistent with available resources and public safety considerations.

MHL §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 themself, as defined above. Authorized reporters include the following: licensed physician, licensed psychologist, registered nurse, or licensed social worker providing treatment, police/peace officer, spouse, domestic partner, child, parent, adult sibling, legal guardian, and supportive or intensive case manager. Peace officers, when acting pursuant to their special duties, police officers, or sheriffs must assist in taking into custody and transporting any such person.

MHL §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, as defined above.

II. *Other Mechanisms for Removal from the Community*

MHL §9.43
Whenever a person is brought before any court and it appears to the court, on the basis of evidence presented to it, that such person has or may have a mental illness which is likely to result in serious harm, or whenever a person before a court in a criminal action appears to have a mental illness which is likely to result in serious harm and the court determines either that the crime has not been committed or that there is not sufficient cause to believe that such person is guilty thereof, the court shall issue a civil order directing their removal to any hospital approved by the Commissioner or, if the person agrees, to a crisis stabilization center.

MHL §9.55
A qualified psychiatrist shall have the power to direct the removal of any person, whose treatment for a mental illness they are either supervising or providing in a facility licensed or operated by the office of mental health which does not have an inpatient psychiatric service, to a hospital approved by the Commissioner, if they determine upon examination of such person that such person appears to have a mental illness for which immediate observation, care and treatment in a hospital is appropriate and which is likely to result in serious harm.

MHL §9.57
A physician who has examined a person in an emergency room or provided emergency medical services at a general hospital which does not have an inpatient psychiatric service shall be authorized to request that the director of the program or hospital, or the director's designee, direct the removal of such person to a hospital approved by the Commissioner, if the physician determines upon examination of such person that such person appears to have a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm.

III. *Involuntary and Emergency Admissions*

MHL §9.27 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.

As per statute, to be involuntarily hospitalized, an individual must have "a mental illness[6] for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." (MHL §9.01)

In order to involuntarily admit the individual, the hospital inpatient psychiatric program must receive an application for admission along with certification of two examining physicians that the individual is in need of involuntary treatment (one of the certifications may be completed by a psychiatric nurse practitioner, after

[6] 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.

August 7, 2025). If the hospital where the application and two certifications were completed does not have psychiatric beds available for the admission, one of the certifying clinicians may request that an ambulance or local peace officer transfer the patient to a receiving hospital that does have available capacity. A psychiatrist at the admitting inpatient service must examine the individual "forthwith" (within 72 hours of the application) and confirm the need for an involuntary 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.

Courts have found in the Matters of Scopes v Shah and Seltzer v Hogue that ***patients can meet criteria for involuntary admission even when there is no recent dangerous act.*** Evaluating psychiatrists may consider an individual's whole history when determining if an individual needs involuntary admission[7]. This may sometimes be referred to as the "Hogue Standard," although it is not different or separate from the general requirements for involuntary admissions.

The following are examples of individuals who would meet criteria for involuntary admission on medical certification[8]:

- 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[9].

- 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[10].

- 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 52lbs (normal for her height would be 100lbs). Patient D continued to restrict caloric intake and intermittently became hyponatremic from polydipsia in an effort to show weight increase without eating.

[7] *Matter of Seltzer v. Hogue*, 187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993).
[8] While these examples are derived from the cited published caselaw, some of the facts may have been altered in this guidance for narrative purposes.
[9] *Rueda v. Charmaine D.*, 17 N.Y.3d 522, 958 NE 2d 106, 934 N.Y.S.2d 72 (2011).
[10] *Matter of Yvette S.*, 163 Misc.2d 902, 622 N.Y.S.2d 879 (Sup. Ct, Queens Cnty. 1995)

Patient D showed extreme difficulty gaining insight into the 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.[11]

- 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.[12]

- 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 was previously admitted for throwing a 150lb bench through a neighbor's windshield, bending the frame and breaking the steering system of the car.[13]

MHL §9.37 Involuntary admission on certificate of a director of community services or his designee

Subsection (a) of MHL §9.37 provides that the director of a hospital, upon application by a director of community services (DCS) or an examining physician duly designated by them, may receive and care for in such hospital as a patient any person who, in the opinion of the director of community services or their designee, has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm, per the definition above. DCSs generally use this provision to facilitate transfer of individuals in behavioral health crisis from Emergency Departments in hospitals without inpatient psychiatric services to other hospitals better equipped to admit these individuals for evaluation and treatment.

Subsection (d) of MHL §9.37 provides that upon the written request of a director of community service (DCS) 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

[11] *Matter of Paulina D.*, 104 A.D.3d 883, 961 N.Y.S2d 320 (N.Y. App. Div. 2013).
[12] *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).
[13] *Seltzer v. Hogue*,187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993)

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 §9.39 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 15 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 that is likely to result in harm. On initial arrival to the Emergency Department or Comprehensive Psychiatric Emergency Program, one physician must examine the individual and determine they meet criteria. The individual cannot be held for more than 48 hours unless a psychiatrist confirms the findings of the first physician's examination.

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."

MHL §9.40 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 medical resident with the medical student present. Based upon the second interview, the resident 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.[14]

Contact

This guidance is intended to provide information about NYS statutes related to involuntary inpatient mental health treatment and is not meant to constitute legal advice. For legal advice about specific individuals in their care, inpatient and emergency services must contact their hospital's attorney. However, clinicians should feel comfortable contacting the OMH Office of Hospital Care and Community Transitions Regional Team at HospitalCare@omh.ny.gov to discuss clinical aspects of specific cases or general questions regarding involuntary care.

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