KATHY HOCHUL
Governor

February 11, 2026

Dear Colleagues,

Please find attached updated joint guidance from the New York State Office of Mental Health (OMH) and New York State Department of Health (DOH) regarding evaluation and discharge practices for individuals who present with behavioral health conditions within psychiatric inpatient programs, Emergency Departments (EDs), and Comprehensive Psychiatric Emergency Programs (CPEPs). This update is aligned with recent changes to 10NYCRR Part 405, Mental Hygiene Law Sections 9.64 and 29.15, and 14NYCRR Parts 580, 582, and 590.

We thank you for your feedback in updating these regulations and for your continued service to the people of New York State.

Sincerely,

Ann Marie T. Sullivan, M.D.
Commissioner
NYS Office of Mental Health

James V. McDonald, M.D., M.P.H.
Commissioner
NYS Department of Health

Guidance on Evaluation and Discharge Practices for Emergency Departments (ED), Comprehensive Psychiatric Emergency Programs (CPEPs), and Article 28 and Private Article 31 Psychiatric Inpatient Programs

February 2026 (Supersedes October 2023 version)

The goal of this document is to offer guidance to hospital-based programs regarding evaluation and discharge planning for individuals who present with behavioral health conditions. This update reflects new provisions in Mental Hygiene Law (MHL) §§9.64 and 29.15, 10 NYCRR Part 405.19, and 14 NYCRR Parts 580, 582, and 590.

This guidance is not applicable to all providers or in all units. Applicability is made clear in each section of the guidance to the following categories of providers and units:

1. EMERGENCY DEPARTMENTS: All Emergency Departments in hospitals regulated under Article 28 of the Public Health Law
2. 9.39 HOSPITAL EMERGENCY DEPARTMENTS: §9.39 hospitals are general hospitals regulated under Article 28 of the Public Health Law **and** have at least one inpatient psychiatric unit licensed under Article 31 of the Mental Hygiene Law
3. COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP): Specialized psychiatric emergency program licensed under Article 31 of the Mental Hygiene Law and 14 New York Code of Rules and Regulations (NYCRR) Part 590.
4. INPATIENT PSYCHIATRIC UNITS: All psychiatric units licensed under Article 31 of the Mental Hygiene Law and 14 NYCRR Parts 580 and 582.
5. ALL PROGRAMS: All Emergency Departments, CPEPS, and Inpatient Psychiatric Units

This guidance details the evaluations that should be completed at each patient encounter, as well as the interventions that will improve patient outcomes; reduce the risk of overdose, self-harm, and violence; and reduce the risk of readmission and disconnection from care. These standards are not intended to replace clinical judgment, but rather to help ensure that clinical staff routinely gather and consider all possible information when making disposition and treatment decisions.

Readers are encouraged to start with the Table of Contents to identify which sections of this guidance are applicable to their program. Sections for “ALL PROGRAMS” are applicable to emergency departments (EDs), comprehensive psychiatric emergency programs (CPEPs), and psychiatric inpatient programs. This guidance does not apply to OMH-operated Psychiatric Centers, which must adhere to additional policies, procedures, and directives.

There are complicated systemic, legal, and regulatory issues that impact the ability of hospital staff to coordinate and collaborate with colleagues in residential, outpatient, and care management programs. Nonetheless, for many patients, there are possible collaborations and interventions that

can lengthen community tenure and help patients achieve meaningfully improved outcomes without repeatedly returning to acute care settings.

As a reminder, psychiatric inpatient programs may not decline to admit individuals who otherwise meet admission criteria solely based on an HIV diagnosis, other chronic medical comorbidity, history of suicide attempt, history of violence, criminal and juvenile justice system involvement, history of personality disorder, diagnosis of substance use disorder, or an intellectual or developmental disability.

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Screening, Assessment, and Gathering Collateral Information

Review Records of Prior Encounters

Psychiatric Inpatient Programs

The attending of record must review emergency department (ED) and comprehensive psychiatric emergency program (CPEP) assessments and interventions and incorporate the information into the overall formulation and treatment plan. Hospitals should also review documentation of prior visits and attempt to obtain medical records from other hospitals where the patient was previously admitted. OMH has issued guidance governing sharing of information among OMH-licensed programs, including when such information can be shared in the absence of specific signed consent.

Suicide Risk

All Programs

All individuals who arrive to EDs with a behavioral health presentation and all individuals served in a CPEP or psychiatric inpatient program must be screened for suicide risk. Use of a validated instrument (e.g., Columbia-Suicide Severity Rating Scale, SAFE-T) is recommended (and required in CPEPs and Inpatient Programs). As part of the screening, individuals should be asked about access to firearms or other weapons. Positive screens must be followed by a suicide risk assessment by a licensed professional trained in assessing suicide risk. The results of this assessment should be considered in the development of the individual's treatment and/or discharge plan.

Substance Use

Emergency Departments

Public Health Law § 2803-u requires hospitals to develop, maintain, and disseminate policies and procedures for the identification, assessment, and referral of individuals with documented substance use disorder or who appear to have or be at risk for substance use disorder and requires them to train their licensed and clinical staff members who provide direct patient care in such policies and procedures. DOH previously issued a Dear Administrator Letter – DHDTC DAL 18-13 – that clinical and program leaders may find useful.

As a best practice, EDs should assess patients for Substance Use Disorders (SUDs) with an age-appropriate and validated instrument (Sample Screening Tools) that specifically screen for different substances (e.g., alcohol, opioids, cannabis, tobacco/nicotine) that may require different acute interventions, management, and referrals. The assessment should include risk of acute withdrawal and risk of accidental overdose. Assessment of acute withdrawal symptoms should include objective information, such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute of Withdrawal Assessment (CIWA) instruments. Any individual determined to be at risk of overdose or of acute withdrawal should be further evaluated and offered necessary treatment. Additionally, at each presentation, a practitioner (a physician, nurse practitioner, or physician assistant as defined by Article 33 of Public Health Law) should check the Internet System for Tracking Over-Prescribing/Prescription Monitoring Program Registry (I-STOP/PMP Registry) for any individual with a positive substance use

screen; any individual who reports a prescription of controlled medications; any individual with a history of overdose; and any individual with a history of withdrawal.

CPEPs and Psychiatric Inpatient Programs

All individuals over the age of 12 must be screened for substance use using a validated instrument (Sample Screening Tools). Instruments should be age-appropriate and specifically screen for individual substances (e.g., alcohol, opioids, cannabis, tobacco/nicotine) that may require different interventions or psychoeducation. Positive screens should be followed by an assessment conducted by a licensed professional who is trained in working with individuals using substances but not necessarily meeting the criteria for a substance use disorder diagnosis (note: a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) certification is NOT a requirement). The assessment should include risk of acute withdrawal and risk of accidental overdose. Assessment of acute withdrawal symptoms should include objective information, such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute of Withdrawal Assessment (CIWA) instruments. Any individual determined to be at risk of overdose or of acute withdrawal should be evaluated and offered necessary treatment. Additionally, at each presentation, a practitioner (a physician, nurse practitioner, or physician assistant as defined by Article 33 of Public Health Law) should check the Internet System for Tracking Over-Prescribing/Prescription Monitoring Program Registry (I-STOP/PMP Registry) for any individual with a positive substance use screen; any individual who reports a prescription of controlled medications; any individual with a history of overdose; and any individual with a history of withdrawal.

Violence Risk

Emergency Departments and CPEPs

All individuals who arrive at EDs with a behavioral health presentation and all individuals served in a CPEP must be screened for risk of violence. Most individuals with behavioral health issues are not violent and are at greater risk of being victims of violence rather than perpetrators. However, there is a small percentage of individuals who do have elevated risk and identifying them early and directing them into treatment is critical to prevent harm and involvement with the criminal justice system.

Each program must have policies regarding violence risk screening. The program policy must describe a process for subsequent assessment and intervention in the case of a positive screen. As part of the screening, all individuals must be asked about access to firearms or other weapons. The screening should include the individual's self-report; a detailed review of the history of present illness; history from electronic health records and other electronic sources; and high-quality collateral information from family, friends, and community providers. Identification of risks for violence (i.e., positive screens) must lead to a more comprehensive clinical assessment that is specifically considered in the development of the individual's treatment and discharge plan.

Psychiatric Inpatient Programs

Each program must have policies regarding violence risk screening. Most individuals with behavioral health issues are not violent and are at greater risk of being victims of violence rather than perpetrators. However, there is a small percentage of individuals who do have elevated risk and

identifying them early and directing them into treatment is critical to prevent harm and contacts with the criminal justice system.

All individuals must be screened, and the program policy must describe a process for subsequent assessment and intervention in the case of a positive screen. As part of the screening, all individuals must be asked about access to firearms or other weapons. The violence risk screening should be repeated as individuals are reassessed throughout their stay in the hospital. The screening should include the individual's self-report; a detailed review of the history of present illness; history from electronic health records and other electronic sources; and high-quality collateral information from family, friends, and community providers. Identification of risks for violence (i.e., positive screens) must lead to a more comprehensive clinical assessment that is specifically considered in the development of the individual's treatment and discharge plan.

COMPLEX NEEDS

ALL PROGRAMS

All individuals who present to EDs with a behavioral health condition or to CPEPs or psychiatric inpatient programs must be screened to determine if they have complex needs as defined by the definition in 14 NYCRR Parts 580, 582, and 590 (below). For adults this definition is aligned with the eligibility criteria for Health Home Plus Care Management to facilitate discharge planning from inpatient settings. For children and youth, the definition is aligned with current enrollment in or eligibility for High Fidelity Wraparound Care Management in Health Homes Serving Children; or eligibility for our current Children's Home and Community Based Service Waiver for children with Serious Emotional Disturbance (SED).

Definition – One or more of the following.

(1) Demonstrate high utilization of inpatient, crisis, or emergency services, as indicated by:

  (i) three or more mental health inpatient hospitalizations in the past year; or

  (ii) four or more mental health presentations to an emergency department (ED) or comprehensive psychiatric emergency program (CPEP) in the past year; or

  (iii) three or more medical/surgical hospitalizations in the last year and carrying a diagnosis of schizophrenia or bipolar disorder.

(2) Discharge from an OMH-licensed residential treatment facility (RTF) in the past year.

(3) Discharge from inpatient level of care at an OMH-operated psychiatric center where the length of stay was greater than 60 days in the past year.

(4) Current enrollment in, or discharge in the past year from, Assertive Community Treatment (ACT), including but not limited to Adult ACT, Youth ACT, Young Adult ACT, Shelter-partnered ACT, and Forensic ACT.

(5) Currently receiving services from Critical Time Intervention (CTI), Safe Options Supports (SOS), Pathway Home, Intensive Mobile Treatment (IMT), Home Based Crisis Intervention (HBCI), or other high-intensity ambulatory service(s).

(6) Eligible for or current enrollment in Health Home Plus Care Management Services.

(7) Eligible for or current enrollment in High Fidelity Wraparound Care Management in Health Homes Serving Children; eligible for or current enrollment in Children's Home and Community Based Services Waiver for children with Serious Emotional Disturbance (SED).

(8) An active Assertive Outpatient Treatment order or an order that expired in the past year.

(9) Experiencing high-risk social needs, including but not limited to, current homelessness, criminal or juvenile justice involvement, and child welfare involvement in the past year.

(10) Clinical determination by staff in the licensed program that, on presentation, the individual has an elevated risk of suicide, violence and/or overdose.

(11) Has a current complexity clinical flag in the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES).

Using PSYCKES to Determine if an Individual Meets the Complex Needs Definition

All Programs

There are many different elements in the Complex Needs Definition, so to assist EDs, CPEPs, and psychiatric inpatient programs in determining which of their patients meet the definition, the State has developed a flag in PSYCKES that can quickly alert hospitals if the definition has been met. Hospital staff are required to login into the PSYCKES application to determine if the Complex Needs Flag is present.

Every hospital in NYS is eligible to have access to PSYCKES. Individual hospital staff access is managed by local Security Managers appointed by hospital leadership. If program leadership is unsure whether the hospital has obtained PSYCKES access or who their assigned Security Managers are, please email PSYCKES-Help@omh.ny.gov (and include in the email name, title, clinical service, and the hospital's name and address. Note: hospitals in different regions of NYS may have similar names). Additional login help can be found here. Training materials can be found here.

Checking PSYCKES and other Electronic Resources

All Programs

In addition to using PSYCKES to check whether a Complex Needs Flag is present, EDs, CPEPs, and psychiatric inpatient programs must also look up individuals in PSYCKES to review their prior psychiatric and medical history, medication history, and treatment engagement history, and obtain contact information for outpatient treatment teams and care managers. Obtaining the individual's consent for PSYCKES gives hospitals access to the individual's clinical summary for 3 years (renewing automatically with any new billed service); however, even if the individual does not have capacity to consent, in emergencies, staff may access the clinical summary for 72 hours. Staff can also check if a Psychiatric Advanced Directive has been uploaded to the individual's clinical summary.

Additionally, if applicable, individuals should be reviewed in any other available information network databases (e.g., the Statewide Health Information Network for New York/Qualified Entities (SHIN-

NY/QE) or Epic Care Everywhere). For individuals who report using controlled medications, their prescription histories should be reviewed in the PMP Registry by authorized practitioners.

Psychiatric Advance Directive (PAD)

All Programs

EDs, CPEPS, and psychiatric inpatient programs should ask if individuals have a psychiatric advance directive (PAD) and incorporate their preferences into the assessment, treatment, and discharge planning. Following the expressed wishes in a PAD can help improve the therapeutic alliance with staff and increase engagement after the individual has been transitioned out of the ED, CPEP, or psychiatric inpatient program.

Obtaining Collateral Information

Emergency Departments

Screenings, assessments, physical and mental status examinations, observation, information from PSYCKES and other health/administrative records, and information gathered from collateral sources are all important factors that must be considered when making disposition decisions. **It is insufficient to make a disposition decision solely based on behavioral observation in the ED setting.**

Where patient consent is required by law and wherever possible, EDs must identify and contact the individual's family members or close friends who interact with the patient to obtain collateral information, including any psychiatric advance directive.

When individuals present on their own to the ED due to a non-emergent reason, including but not limited to, an asymptomatic individual presenting for a medication refill, collateral information may not be required provided the remainder of the evaluation is not concerning, the individual has low risk for harm, and they are well-connected to community services.

When assessing individuals who are brought in by the police due to behavioral disturbances in the community or individuals who are involuntarily removed from the community (i.e., pursuant to Mental Hygiene Law (MHL) §9.37, 9.41, 9.45, 9.58, or 9.60), EDs should obtain collateral information from the party who initiated the involuntary removal and from other important sources of information, including family members and friends, outpatient providers, residential or long-term care programs, health home care managers, Adult/Children's Single Point of Access (SPOA/C-SPOA), schools, child welfare, parole/probation/persons in need of supervision (PINS) officers, and/or Medicaid Managed Care (MCO) care managers.

When contacting sources of collateral information, EDs must assess whether the source is able to provide sufficiently high-quality information to determine risk, symptomatology, and functioning in the community; treatment history; engagement in treatment; and ongoing stressors. If the source is not able to provide sufficiently high-quality information, attempts should be made to identify and contact additional sources of collateral information.

CPEPs

Acquiring collateral information is a foundational component of a CPEP Evaluation. Screenings, assessments, physical and mental status examinations, observation, information from PSYCKES and other health/administrative records, and information gathered from collateral sources of information are all important factors that must be considered when making disposition decisions. **It is insufficient to make a disposition decision solely based on behavioral observation in the CPEP setting.**

Where patient consent is required by law and wherever possible, CPEPs must identify and contact the individual's family members or close friends who interact with the patient to obtain collateral information, including any psychiatric advance directive.

When individuals present on their own to the CPEP due to a non-emergent reason, including but not limited to, an asymptomatic individual presenting for a medication refill, collateral information may not be required provided the remainder of the evaluation is not concerning, the individual has low risk for harm, and they are well-connected to community services.

Mental Hygiene Law §9.64 (effective August 2025) requires CPEP leadership to ensure that reasonable efforts are made to identify and promptly notify any community provider of mental health services currently serving any patient who is accepted into the CPEP.

When assessing individuals who are brought in by the police due to behavioral disturbances in the community or individuals who are involuntarily removed from the community (i.e., pursuant to Mental Hygiene Law (MHL) §9.37, 9.41, 9.45, 9.58, or 9.60), CPEPs should obtain collateral information from the party who initiated the involuntary removal and other important sources of information, including family members and friends, outpatient providers, residential or long-term care programs, health home care managers, Adult/Children's Single Point of Access (SPOA/C-SPOA), schools, child welfare, parole/probation/persons in need of supervision (PINS) officers, and/or Medicaid Managed Care (MCO) care managers.

OMH has issued guidance that details when information sharing is permitted even without specific signed consent, which includes clinical communication among CPEPs and OMH-licensed outpatient services. OMH has also issued guidance to outpatient, residential, and care management providers on proactively contacting CPEPs to communicate the reason individuals were transported to the hospital.

When contacting sources of collateral information, CPEPs must assess whether the source is able to provide sufficiently high-quality information to determine risk, symptomatology and functioning in the community; treatment history; engagement in treatment; and ongoing stressors. If the source is not able to provide sufficiently high-quality information, attempts should be made to identify and contact additional sources of collateral information.

Psychiatric Inpatient Programs

Acquiring Collateral Information is a Foundational Component of Inpatient Psychiatric Treatment. Screenings, assessments, physical and mental status examinations, observation, information from PSYCKES and other health/administrative records, and information gathered from collateral sources of information are all important factors that must be considered when making treatment and disposition decisions. It is insufficient to make a disposition decision solely based on behavioral observation in the inpatient unit.

With the individual's consent where required by law, hospitals must identify and contact the individual's family members or close friends who interact with the patient to obtain collateral information, including any psychiatric advance directive. Collateral information must also be obtained from outpatient and residential providers, particularly if the individual was admitted as a result from outpatient or residential providers activating EMS.

Mental Hygiene Law §9.64 (effective August 2025) requires psychiatric inpatient program leadership to ensure that reasonable efforts are made to identify and promptly notify any community provider of mental health services current serving any patient who is admitted into the inpatient unit.

OMH has issued guidance that details when information sharing is permitted even without specific signed consent, which includes clinical communication among inpatient psychiatric units and OMH-licensed outpatient services as well as additional services.

When contacting sources of collateral information, inpatient programs should assess whether the source is able to provide sufficiently high-quality information to determine risk, symptomatology and functioning in the community, treatment history, engagement in treatment, and ongoing stressors. If the source is not able to provide sufficiently high-quality information, attempts should be made to identify and contact additional sources of collateral information.

Evaluations of Individuals with Frequent Presentation

Emergency Departments and CPEPs

There are individuals who frequently present to EDs and/or CPEPs due to difficulty establishing social connections or unmet basic needs, such as food, safety, housing, etc. (i.e., primary or secondary gain). Additionally, children and adolescents may present frequently due to reactive or maladaptive behaviors.

While these individuals may be familiar to staff, there is always the possibility of new or worsening medical, psychiatric, or other conditions. Staff may develop preconceived notions due to challenging behaviors by these individuals, and these preconceived notions may be influenced by implicit bias.

These individuals should be assessed at **each presentation** to ensure they obtain the care they need and EDs and CPEPs do not miss treatable conditions or intervention opportunities. They should not be reflexively discharged or have their concerns dismissed based on evaluations in prior visits.

Level of Care Determination

All Programs

When making admission or discharge decisions, it is a best practice to consider an individual's own stated goals and, for minors, the parent/guardian's goals (as appropriate). Also consider current symptoms, risk assessment based on information from collateral sources and observation onsite, overall clinical history, engagement in care, and availability of existing services in the surrounding community.

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) by the American Associations for Community Psychiatrists (AACP) and the Child and Adolescent Service Intensity

Instrument (CASII) by the American Academy of Child and Adolescent Psychiatrists (AACAP) are peer-reviewed, evidence-based instruments that hospitals should consider adopting to navigate this complexity and ensure admission decisions are consistent and have a rational basis.

Involuntary or Emergency Admissions

Emergency Departments and CPEPs

Individuals at an elevated risk for harming themselves or others, who are functionally impaired to the point of being unable to meet their basic needs, or who have multiple comorbidities that prevent community-based treatment may need an involuntary admission.

The State Office of Mental Health (OMH) has previously issued guidance on involuntary and emergency admissions and certain situations where they are appropriate.

There are times when practitioners may determine that an inpatient admission is beneficial to an individual even if the individual does not meet involuntary or emergency admission criteria. In these cases, the individual over 16 should be offered a voluntary 9.13 admission. For individuals under 16, the following may apply for a voluntary 9.13 admission:

- A parent, legal guardian, or next of kin;
- a Social Services official or authorized agency with care and custody of the person pursuant to the Social Services Law, subject to the terms of any court order or any instrument executed pursuant to Section 384-a of the Social Services Law;
- the Commissioner for the New York State Office of Children and Family Services (OCFS), acting in accordance with Section 509 of the Executive Law;
- a person or an authorized representative of an entity having custody of the person pursuant to Section 756 or Section 1055 of the Family Court Act.

Appropriateness for Assisted Outpatient Treatment (AOT)

Psychiatric Inpatient Programs

Individuals who have an elevated risk or frequent admissions due to non-compliance should be evaluated to determine if Assisted Outpatient Treatment (AOT) would be beneficial. In August 2023, OMH issued guidance for physicians on conducting an AOT evaluation. Additional guidance on AOT can be found here.

Coordinated Discharge Planning

Consider the Whole Person

All Programs

When determining whether an individual can be discharged and the most appropriate discharge setting, the whole clinical presentation and history, co-occurring conditions, collateral information, as well as the availability of existing services and supports in the individual's community, must be

considered. The plan must be developed through shared decision-making and reflect individual strengths.

Consider Health-Related Social Needs and Social Determinants (HRSNs) in Discharge Planning

All Programs

This section does not apply to all EDs, rather only EDs in 9.39 hospitals discharging individuals with complex needs.

Hospitals must consider Health-Related Social Needs (HRSNs) when planning discharges of individuals with complex needs. When submitting claims for services, including the ICD-10 Social Determinants of Health Z codes in the claims, as appropriate, would greatly assist the State's data for public health analyses and future investments.

Appointment Within Seven Calendar Days

9.39 hospital Emergency Departments

This section does not apply to all EDs, rather only EDs in 9.39 hospitals discharging individuals with complex needs.

Hospital EDs must schedule and confirm an appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge. A referral to a walk-in intake clinic alone is not a best practice to meet this requirement.

If, after making diligent efforts, a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the hospital shall document its efforts, including efforts to schedule the appointment for as soon as possible thereafter. In the extraordinary event an appointment for psychiatric aftercare cannot be secured at all (please refer below for finding outpatient mental health programs), the hospital shall document its efforts before discharging the patient and provide such documentation to the Department of Health upon request.

If you have difficulty making an appointment for psychiatric aftercare within 7 days, please contact HospitalCare@omh.ny.gov. Please include in your message the best way for the OMH Regional Team to connect with the correct person in the ED.

Individuals who are leaving the hospital against medical advice or who state they do not wish to receive aftercare services must be offered information about available treatment options and should have an appointment scheduled whenever possible. Offering appointments and information about treatment resources significantly increases rates of successful care transitions, even among those patients who decline aftercare and are at the greatest risk for readmission and other poor outcomes.

CPEPs

Hospitals must schedule and confirm an appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge. If, after making diligent efforts, a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the

hospital shall document its efforts, including efforts to schedule the appointment for as soon as possible thereafter.

A referral to a walk-in intake clinic is insufficient to meet this requirement. When an appointment for mental health services cannot be made within seven calendar days, crisis outreach teams or other available CPEP staff shall provide crisis outreach until the initial appointment occurs.

Individuals who are leaving the hospital against medical advice or who state they do not wish to receive aftercare services must be offered information about available treatment options, and have an appointment scheduled whenever possible. Offering appointments and information about treatment resources significantly increases rates of successful care transitions, even among those patients who decline aftercare and are at the greatest risk for readmission and other poor outcomes.

If you have difficulty making an appointment for psychiatric aftercare within 7 days, please contact HospitalCare@omh.ny.gov. Please include in your message the best way for the OMH Regional Team to connect with the correct person in the CPEP.

Psychiatric Inpatient Programs

Hospitals must schedule and confirm an appointment for psychiatric aftercare with an identified provider within seven calendar days following discharge. A referral to a walk-in intake clinic is insufficient to meet this requirement.

If, after making diligent efforts, a hospital cannot identify an aftercare provider with an available appointment within seven calendar days, the hospital shall document its efforts, including efforts to schedule the appointment for as soon as possible thereafter.

A referral to a walk-in intake clinic is insufficient to meet this requirement.

Individuals who are leaving the hospital against medical advice or who state they do not wish to receive aftercare services must be offered information about available treatment options and have an appointment scheduled whenever possible. Offering appointments and information about treatment resources significantly increases rates of successful care transitions, even among those patients who decline aftercare and are at the greatest risk for readmission and other poor outcomes.

If you have difficulty making an appointment for psychiatric aftercare within 7 days, please contact HospitalCare@omh.ny.gov. Please include in your message the best way for the OMH Regional Team to connect with the correct person on the unit.

Finding Outpatient Mental Health Programs

All Programs

PSYCKES can alert hospitals where an individual may already be receiving services (or has previously received services). Connecting with current or recent outpatient providers for aftercare can ensure continuity and improve engagement.

OMH has an online mental health program directory that provides information on all programs in New York State that are operated, licensed, or funded by OMH. This site includes three search options: Basic Search, Advanced Search, and Full Directory. Advanced Search offers the most options to

narrow results by multiple criteria. Definitions for all programs are available under the Support tab, along with directory help and information on program data collection.

Hospital leadership should foster a working relationship with the Directors of Community Service (DCS) of the Counties in their catchment area. The DCS oversees behavioral health for the County government. Every year, the County is required to develop a Local Services Plan (LSP) and the DCS is familiar with local outpatient resources. The Single Point of Access (SPOA) and Children's Single Point of Access (C-SPOA) in each county DCS office are specific contacts for locating resources.

The OMH Office of Hospital Care and Community Transition Regional Teams are developing County-specific referral resources which will be disseminated when complete and will be maintained. For more information on this resource, please contact HospitalCare@omh.ny.gov.

OMH is investing in an expansion of Certified Community Behavioral Health Centers (CCBHCs), designed to treat both mental health and substance use disorder needs; Safe Options Support (SOS) Teams for individuals experiencing homelessness; and Critical Time Intervention (CTI) to provide time-limited care management to help individuals connect to outpatient longitudinal services. Forming relationships with these programs as they develop will lead to better referral options and additional assistance for individuals to access outpatient services. These programs can be found in the online directory mentioned above.

OMH clinics, formally known as Mental Health Outpatient Treatment and Rehabilitation Services (MHOTRs), and CCBHCs are required in regulations to prioritize referrals from hospitals. Most §9.39 Hospitals operate outpatient mental health services – approximately 70% operate clinics/MHOTRs programs. While referrals should be individualized to the needs of each patient, leadership of Emergency and Outpatient Behavioral Health Departments should develop workflows to facilitate internal referrals when a clinic/MHOTR is the most appropriate next level of care.

Medicaid Managed Care and other managed plans are required to support their members in seeking appropriate care. Building a relationship with insurers that cover high percentages of individuals who present to the hospital can also be a source of information on available resources in the community. New network adequacy laws and regulations require insurers to assist patients and hospitals locate in-network services or approve services by out-of-network providers at no additional cost-sharing. Know Your Rights and Governor's Announcement.

Psychiatric Inpatient Programs

Individuals who might benefit from more socialization, psychoeducation, and/or psychosocial rehabilitation can be referred to Personalized Recovery Oriented Services (PROS) programs or local Clubhouse programs. PROS programs often have an affiliated clinic that can provide ongoing pharmacological treatment.

Discharge Summary

All Programs

This section does not apply to all EDs, rather only EDs in 9.39 hospitals discharging individuals with complex needs.

Within seven days of discharge, the program must forward a written discharge note detailing the history of present illness, hospital course, and other relevant information to the outpatient, residential, and/or long-term care treatment program.

Coordination with Care Managers

All Programs

This section does not apply to all EDs, rather only EDs in 9.39 hospitals discharging individuals with complex needs.

If the individual is enrolled in a care management program (e.g., Health Home, Health Home Plus, High Fidelity Wraparound, active AOT order, ACT), the hospital must coordinate discharge planning with the care management program. Hospitals should invite care managers into the program to meet with the patient (and guardian(s), if the patient is a minor), even when the care manager is not an employee or otherwise affiliated with the hospital.

Warm Handoffs/Verbal Sign-out

CPEPs and Psychiatric Inpatient Programs

For individuals with complex needs, the discharging CPEP or Psychiatric Inpatient Program must provide a verbal clinical sign-out on the day of discharge, or as soon as possible thereafter to the receiving outpatient program. If applicable, verbal sign-out should also be given to residential programs (licensed or funded by OMH, the Office of Addiction Services and Supports (OASAS), the Office for People with Developmental Disabilities (OPWDD), or the DOH) where the individual will reside after discharge. This must be done in accordance with section 33.13 of the Mental Hygiene Law, for which additional guidance can be found here.

Initiating Care Management Referrals

CPEPs

For individuals with complex needs who are enrolled in a Medicaid Managed Care Organization (MCO) and who are eligible but not enrolled in intensive care management or who need more intensive care management, CPEPs must call the MCO and inform an MCO Care Manager of the discharge.

Psychiatric Inpatient Programs

For individuals with complex needs who are eligible but not enrolled in intensive care management or who need more intensive care management, the hospital must make a referral to an intensive care management program (e.g. Health Home Plus, High Fidelity Wraparound).

Pre-Discharge Interventions to Improve Discharge Outcomes

Peer Programs

CPEPs

CPEPs with established Peer Specialist programs should have Peers engage individuals during their stay to develop rapport, diminish stigma, share resources, and encourage ongoing care. Peer Specialists should also assist individuals with accessing additional supports in the community to promote integration and recovery.

Psychiatric Inpatient Programs

If the hospital has Peer Support Services, peers can engage individuals during their stay to develop rapport, diminish stigma, share resources, and encourage ongoing care. They should also assist individuals with accessing additional supports in the community to promote integration and recovery.

Community Suicide Safety Plan

Emergency Departments

It is a recommended best practice that individuals with an elevated risk of self-harm or suicide have a community suicide safety plan completed before discharge (e.g. the Stanley-Brown Brief Intervention). This plan should be developed with the individual and shared with outpatient, residential, and/or long-term care providers. For minors living with their family, the family should be part of planning.

CPEPs and Psychiatric Inpatient Programs

All individuals must be screened for suicidality prior to their discharge. Individuals with an elevated risk of self-harm or suicide must have a community suicide safety plan completed before discharge (e.g. the Stanley-Brown Brief Intervention). The plan must be developed collaboratively and rooted in the individual's history – the plan is not merely a prepopulated form that is handed to the individual. Lethal means shall be identified and a plan for their restriction addressed. Hospitals shall document their work with outpatient and residential programs to communicate and implement the plan. For minors living with their family, the family should be part of planning.

Mitigating Risk of Violence in the Community

Emergency Departments

It is a recommended best practice that discharge of individuals with an elevated risk of violence include close collaboration with key community partners (e.g., current outpatient, residential, or long-term care provider, care managers, shelters, the local government unit, peer advocates) in the overall strategy to address violence risk factors and access to weapons.

CPEPs

Discharge of individuals with an elevated risk of violence shall include, to every extent possible, close collaboration with current and new outpatient providers, residential providers if applicable, school if applicable, and the County Director of Community Service (DCS) to incorporate strategies to address violence risk and access to weapons into the overall discharge plan. Peer Specialists should be engaged to help with discharge planning for these individuals. Coordination must be done in accordance with protected health information (PHI) privacy laws; please see additional guidance on information sharing.

Psychiatric Inpatient Programs

Discharge of individuals with an elevated risk of violence shall include close collaboration with current and new outpatient providers, residential providers if applicable, school if applicable, and the County Director of Community Service (DCS) to incorporate strategies to address violence risk and access to weapons into the overall discharge plan. Coordination must be done in accordance with protected health information (PHI) privacy laws; please see additional guidance on information sharing.

Addressing Substance Use

All Programs

It is a recommended best practice that individuals at risk for an opioid overdose or who live with someone at risk be dispensed or prescribed naloxone and given education on how to use it. These individuals should also be educated on how to obtain naloxone in the community after discharge. Additional education about harm reduction strategies, such as never using alone, using fentanyl test strips, and information about contaminants should be provided to individuals at risk or living with someone at risk of overdose.

It is a recommended best practice that individuals who meet criteria for opioid use disorder be offered buprenorphine or long-acting naltrexone, if appropriate, and referred to an outpatient provider who can continue the treatment and be given a bridge prescription until the appointment. Similarly, individuals who meet criteria for alcohol or tobacco use disorders should be offered appropriate pharmacological interventions and referred to a new or existing provider who can continue the treatment.

Long-Acting Injectable Medications

Emergency Departments and CPEPs

For individuals on assisted outpatient treatment (AOT) orders, EDs and CPEPs should offer and administer missed doses of long-acting injectable medications when clinically appropriate.

Psychiatric Inpatient Programs

Individuals who need treatment with antipsychotic medication who have a known history of having difficulty consistently taking medications post-discharge should be considered for treatment with a long-acting injectable antipsychotic medication. If appropriate, the induction dose(s) should be administered prior to discharge. Similarly, individuals who may benefit from long-acting injectable naltrexone or buprenorphine should receive their induction dose prior to discharge.

Psychiatric Advance Directives

CPEPs and Psychiatric Inpatient Programs

If, on presentation, the individual did not have a Psychiatric Advance Directive (PAD), the program shall provide a copy and explanation of the PAD once the individual is no longer in crisis. If the individual chooses to complete a PAD, it should be incorporated into the treatment and discharge plan, placed in the chart, and forwarded along with other discharge information to the receiving

outpatient or residential provider. For individuals enrolled in Medicaid, staff should upload the PAD into PSYCKES (please see instructions). PADs detail an individual's preferences for future mental health treatment decisions and may name an individual to make treatment decisions if the individual is in a crisis and unable to make decisions. An example of a PAD can be found here.

Conclusion

Hospital Programs are a Critical Foundation of the Mental Health System

Clinicians, administrators, and other staff who serve patients in EDs, CPEPs, and Psychiatric Inpatient Units are true heroes in New York's Mental Health System who have shown their dedication in ever increasing ways since the beginning of the COVID-19 pandemic, through the post-COVID behavioral health crisis, and into an ever more complex fiscal environment. Recent changes to Mental Hygiene Law and NYS Regulations are aimed at ensuring that the system in its entirety better communicates and coordinates to help New Yorkers with behavioral health needs get the care they deserve. The NYS Department of Health and Office of Mental Health are deeply thankful to all hospital staff for implementing these new requirements and recommended best practices to reduce readmissions and hopefully prevent tragic outcomes.

Technical Assistance & Support for All Programs

OMH's Office of Hospital Care and Community Transitions (OHCCT) has six regionally-based teams focused on providing technical assistance and support to OMH-licensed Article 28 and 31 hospital programs. OHCCT is collaborating with DOH to support 9.39 Emergency Departments in meeting the needs of individuals with behavioral health crises. To connect with OHCCT, please contact HospitalCare@omh.ny.gov.