Admission and Discharge Practices of Psychiatric Hospitals

A Report to the New York State Legislature
Pursuant to Chapter 50 of the Laws of 1987

NYS Commission on

QUALITY OF CARE for the Mentally Disabled

Clarence J. Sundram
CHAIRMAN

Irene L. Platt
James A. Cashen
COMMISSIONERS

April 1988

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PREFACE

This report and its recommendations represent the culmination of many informal and formal research approaches by the Commission to better understand the difficulties faced by New York's inpatient psychiatric facilities and the underlying problems contributing to them. The Commission's conclusions and recommendations advocate for a substantial re-thinking of the types of community-based services needed by New York's citizens with serious mental illness, and, specifically for a re-evaluation of the costly overutilization of inpatient psychiatric facilities in responding to the needs of these individuals and their families.

In the conduct of this review, Commission members and staff interviewed literally scores of program administrators and front-line staff, local and State officials, former and current recipients of services, and family members of persons with mental illness. A draft of the report and its recommendations was also shared with many key players in New York's health and mental health systems and with the members of the Commission's Advisory Council for its Protection and Advocacy Program for Mentally Ill Individuals.

The conclusions and recommendations contained in the report reflect the unanimous opinion of the Commission. In addition, and as reflected in the letters of comment to the draft report presented in Appendix A, the report's recommendations have also received virtually unanimous support from State and local health and mental health officials asked to review the draft report.

Clarence J. Sundram
Chairman

Irene L. Platt
Commissioner

James A. Cashen
Commissioner

ACKNOWLEDGEMENTS

The Commission wishes to acknowledge the many administrators and staff of inpatient psychiatric facilities, current and former recipients of mental health services and family members of individuals with mental health problems who so willingly offered their perceptions, concerns, and recommendations in the conduct of this review.

Special thanks are extended to administrators and staff who so cordially accommodated Commission interview teams visiting their facilities and to those individuals who reviewed and offered written comments on the draft report and its recommendations. The Commission would also like to acknowledge Dr. Joseph T. English, Director of Psychiatry, St. Vincent's Hospital, and Chairman, Mental Health/Substance Abuse Services Committee, Greater New York Hospital Association; Dr. Luis R. Marcos, Vice President of Mental Hygiene Services, New York City Health and Hospitals Corporation; and Dr. Richard C. Surles, Commissioner of the New York State Office of Mental Health, for their support in the conduct of this review, and particularly for their gracious assistance in facilitating candid interviews with staff on the front lines of service delivery.

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INTRODUCTION

Chapter 50 of the Laws of 1987 required the Commission to conduct a study of admission and discharge practices of mental hygiene facilities providing inpatient psychiatric services. This legislative directive reflected widespread concerns over the functioning of portions of the mental hygiene system.

- During the summer and fall of 1986, there had been a significant exacerbation of the chronic and severe overcrowding experienced by psychiatric emergency rooms and acute inpatient psychiatric wards in New York City. This exacerbation occurred in the wake of the killings of and assaults upon passengers on the Staten Island Ferry by a patient recently discharged from a psychiatric emergency room.

- In the spring of 1987, there had been a number of leaves without consent and escapes from locked wards at Creedmoor Psychiatric Center, and two of the patients who had left were later found dead in the community.

- Families with mentally ill relatives continued to voice dissatisfaction with the frequent unavailability of mental health services in times of crisis, and with rapid discharges from inpatient care without adequate family involvement in planning or adequate follow-up services.

This report represents the major conclusions and recommendations of the Commission to the New York State Legislature.

A preliminary draft of this report has been reviewed by a number of State and local officials involved in the mental hygiene system. Their comments are attached in Appendix A to this report.

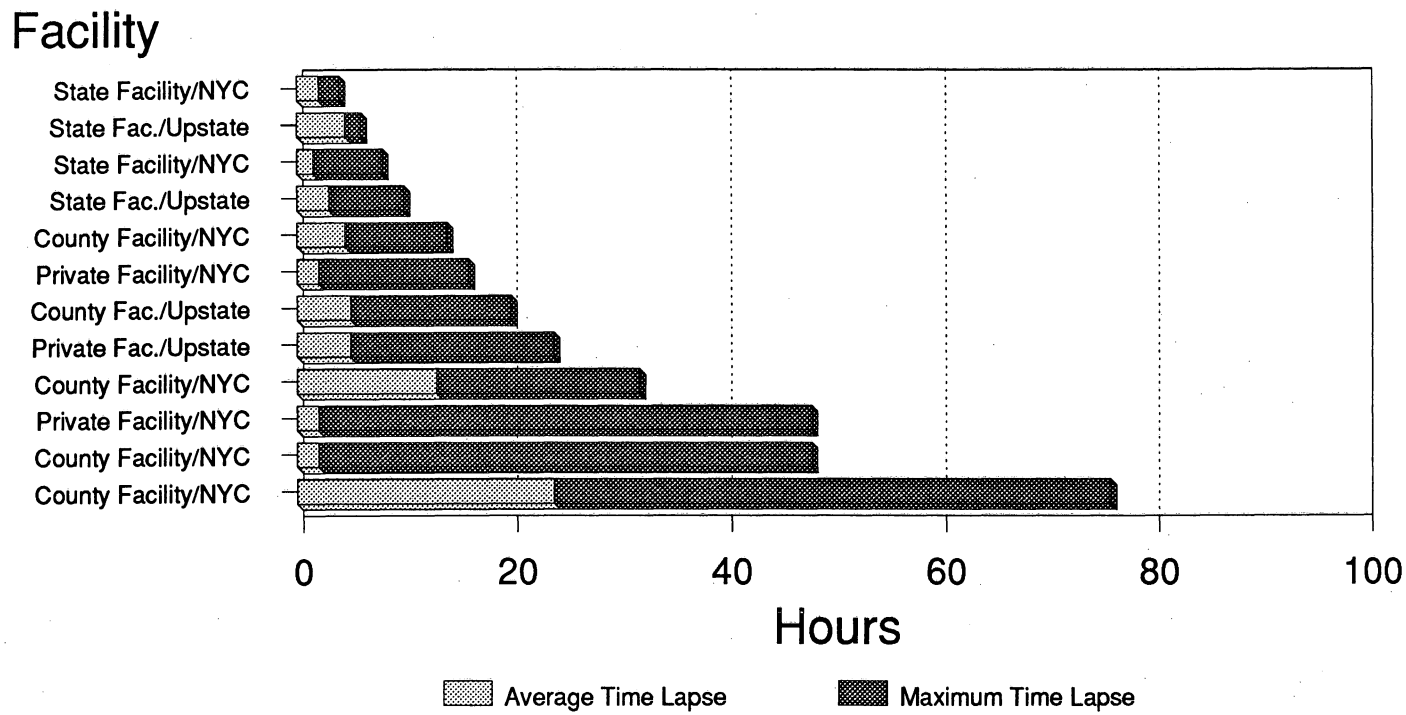
METHODOLOGY

In responding to the legislative directive, the Commission began by conducting nearly two dozen meetings with recipients of services, family members, facility administrators, senior clinicians, and providers of community mental health services to discuss their perceptions of the strengths and weaknesses of existing admission and discharge practices and to identify areas in need of attention. Also, the recently concluded public forums held by the Commission in five regions of the State provided valuable testimony about public concerns with the availability and quality of mental health services.

In addition to these meetings and forums, the Commission:

- conducted a mail survey of all State, local, private and voluntary psychiatric facilities to gather data on admission and discharge practices;
- conducted in-depth interviews with staff of 12 inpatient psychiatric facilities in urban areas across the State. The facilities included State, municipal and voluntary hospitals;
- gathered and analyzed data on leaves without consent and escapes from inpatient psychiatric facilities to determine the nature and dimension of the problem;
- identified and examined the circumstances surrounding the deaths of 41 patients during a three-year period, 1984-86, who had left inpatient psychiatric facilities without consent;
- followed a random sample of 60 patients discharged from five inpatient psychiatric facilities for a six-month period to gain a more specific understanding of how existing policies and practices had affected the care of these patients; and
- studied the special problems of a group of mentally retarded or dually diagnosed patients in inpatient psychiatric facilities in New York City to gain a better understanding of the factors precipitating admission, the types of services received, and the barriers to discharge of these patients who experience extraordinary lengths of stay.

Figure 1: Time Lapse Between Presenting for Admission At Emergency Room and Securing a Bed*



*Based on Commission indepth interviews at eight NYC and four upstate urban inpatient facilities (December, 1987)

FINDINGS

A System Under Stress

There is a widely shared perception among recipients of service, families, clinicians, front line workers and facility administrators that mental health services are operating under significant stress from seemingly unlimited demands for services, coupled with a finite supply and limited range of services with which to respond to the needs presented. While urban areas of the State are particularly affected, State psychiatric centers in outlying areas are increasingly feeling the ripple effects of this stress as a result of frequent transfers of patients to relieve overcrowding in urban facilities, or sudden changes in the roles they had traditionally performed, i.e., admission of acutely ill patients to facilities which had traditionally provided intermediate and long-term care.

Overcrowding

Symptoms of this state of stress include severe overcrowding in virtually every segment of mental health services, particularly in urban areas.

1. Psychiatric emergency rooms report that patients are often held beyond the 24-hour limit established by regulations of the Department of Health. Of the 12 hospitals visited by the Commission staff, one-third reported holding patients in emergency rooms for more than 24 hours and sometimes for 48 to 72 hours, while awaiting availability of an inpatient psychiatric bed. (Figure 1) It should be noted that these emergency rooms frequently lack the physical space or other facilities in which to appropriately care for patients who are believed to be acutely mentally ill.

2. Inpatient psychiatric units of municipal and voluntary hospitals regularly operate at or over their authorized capacity. Sixty-two percent of the municipal and voluntary hospitals responding to our survey reported being at or over capacity with annual occupancy rates ranging from 91 percent to 110 percent. (Figure 2)

3. State psychiatric center wards frequently have more patients than they are staffed or equipped to serve. Ninety-two percent of these facilities responding to our survey reported annual occupancy rates of more than 90 percent, and 33 percent reported annual occupancy rates in the 101-110 percent range. (Figure 3)

This overcrowding has led to the transfer of patients directly from psychiatric emergency rooms to State psychiatric centers through so-called "tripwire" agreements and the transfer of longer term patients from crowded urban State psychiatric centers to less crowded suburban and rural facilities, creating substantial turmoil for patients and families, staff and administrators. According to the OMH Five Year Plan Update,* 5,515 New York City residents are receiving inpatient psychiatric care in State psychiatric centers in other regions of the State. (Figure 4) In addition, significant numbers of patients from Buffalo and Rochester psychiatric centers have been transferred to other State psychiatric centers.

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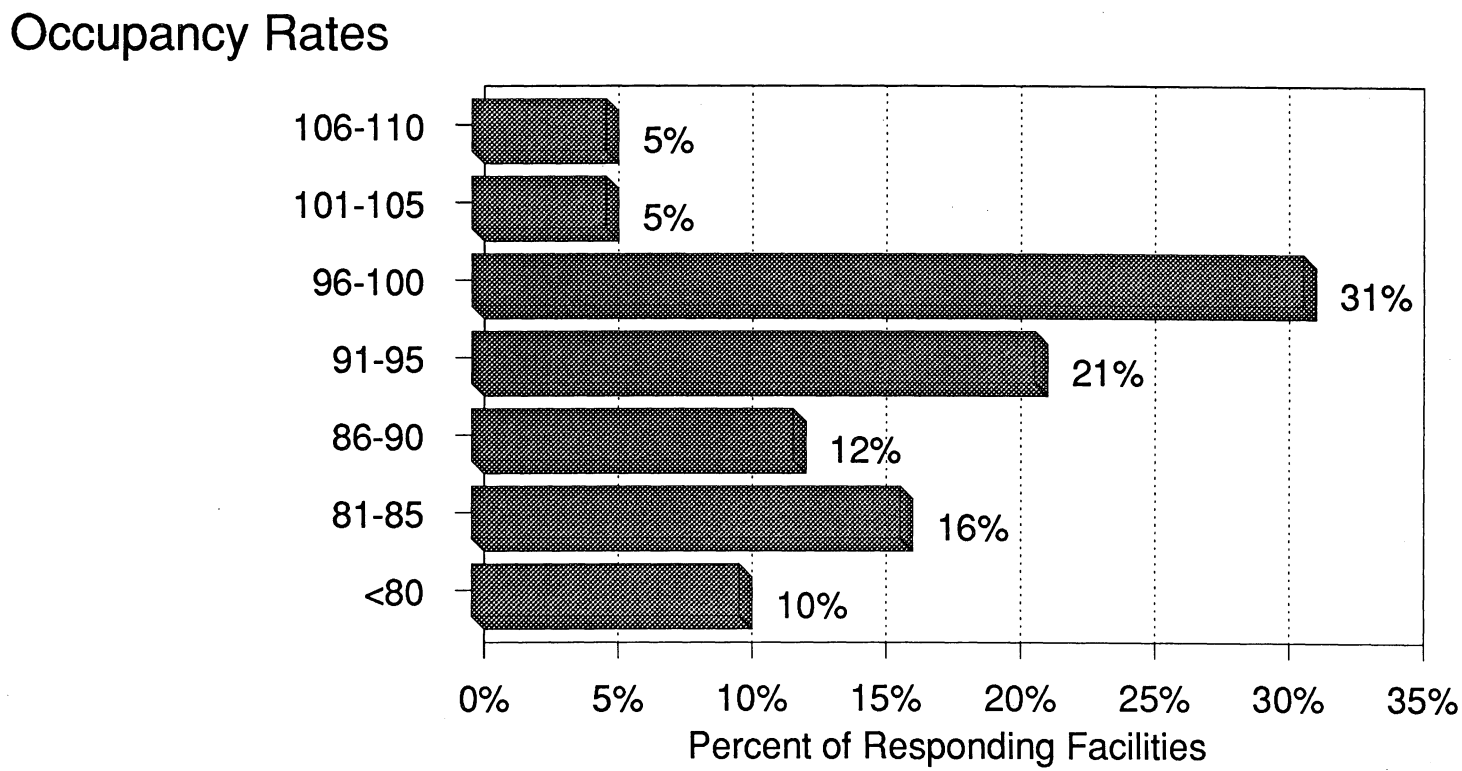
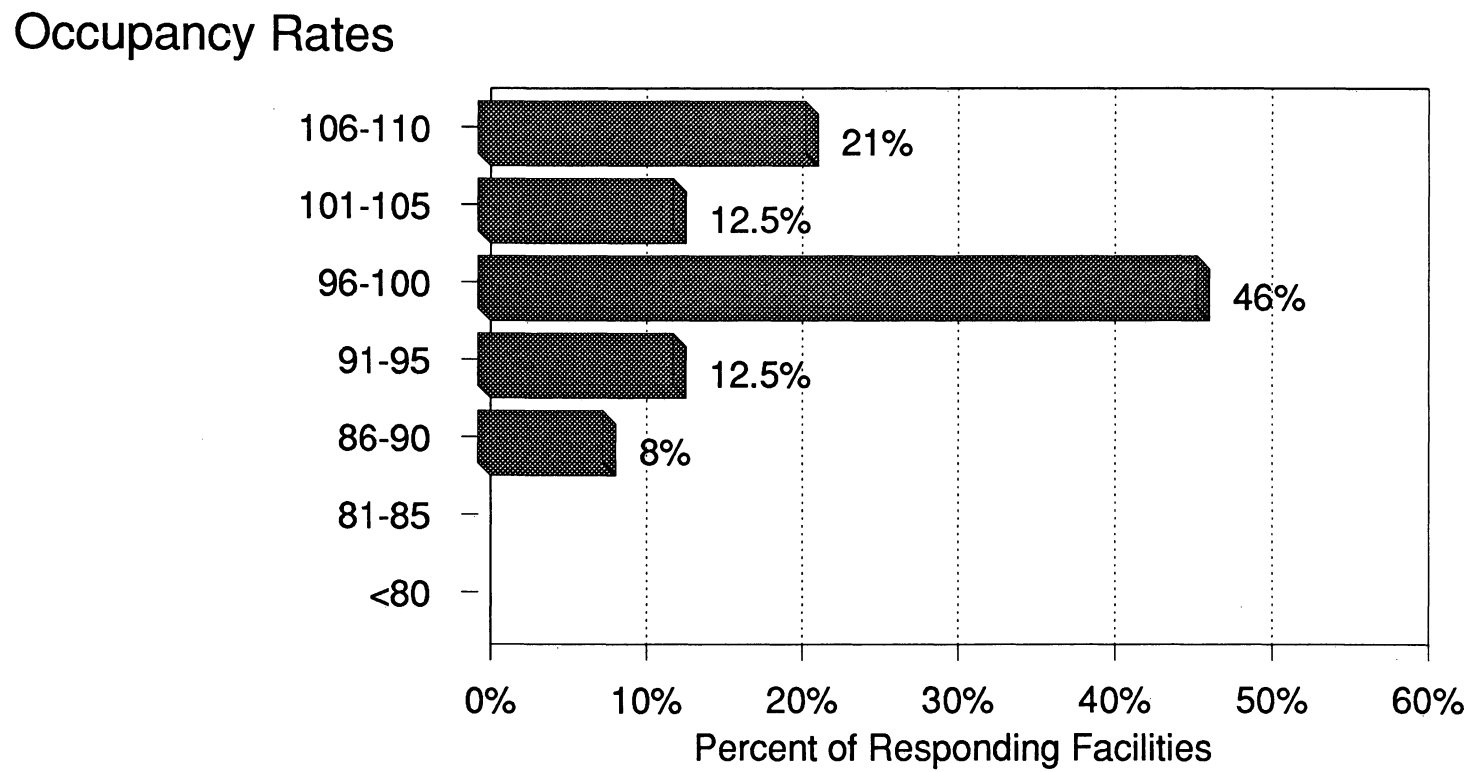
* *1985-1990 Five Year Comprehensive Plan for Mental Health Services: 1988 Update and Progress Report;* New York State Office of Mental Health, October 1987.

Figure 2: Distribution of Private and Municipal Hospital Psychiatric Unit Annual Occupancy Rates: 1987 Survey*



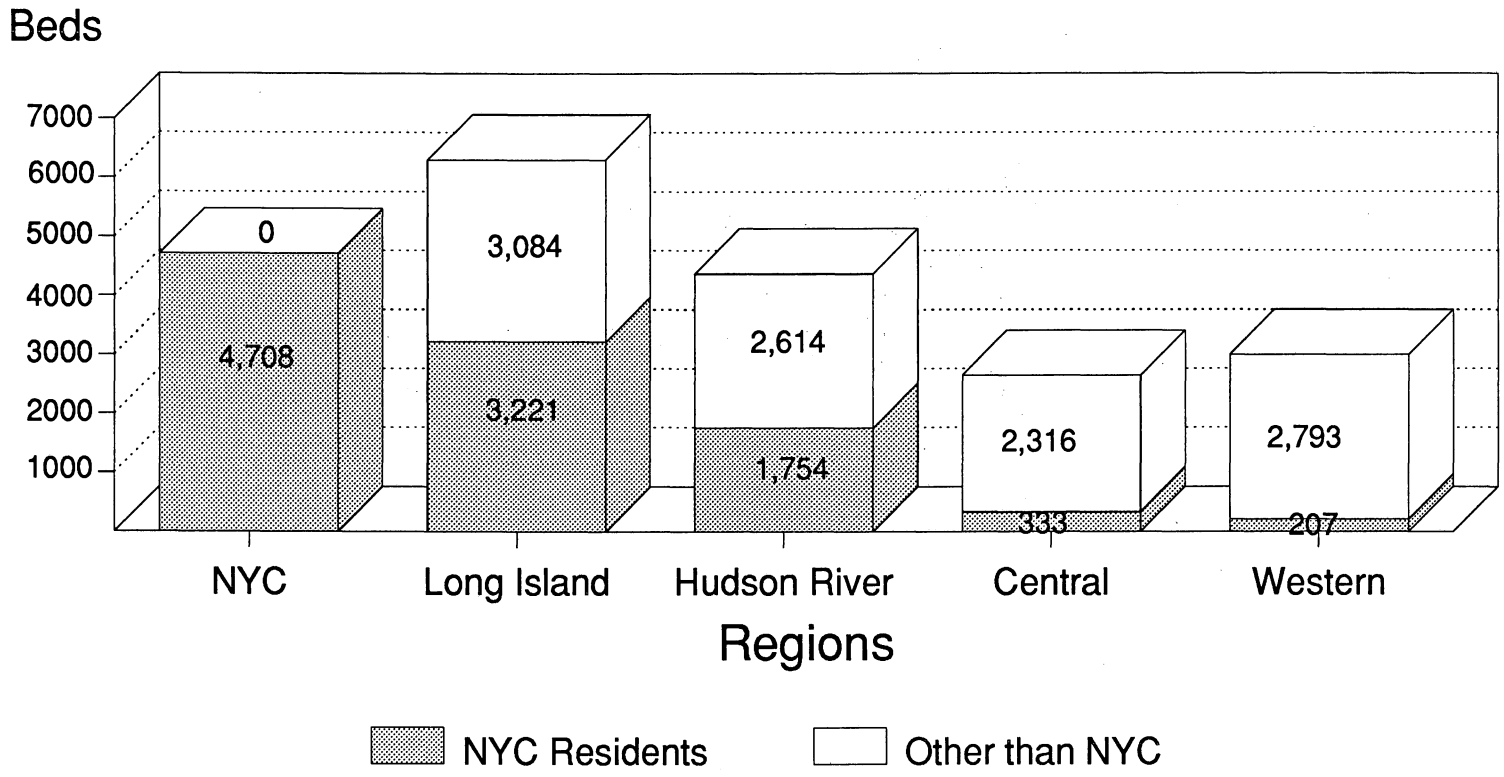
*Based on survey responses from 77 of the 109 licensed psychiatric facilities statewide.

Figure 3: Distribution of State Psychiatric Center Annual Occupancy Rates: 1987 Commission Survey*



*Based on survey responses from 24 of the 26 State psychiatric centers statewide.

Figure 4:Distribution of NYS Psychiatric Center Beds By Region and Beds Serving NYC Residents 3/31/87*



*Data from the 1985-1990 Five Year Comprehensive Plan for Mental Health Services:1988 Update and Progress Report.

Services Often Unavailable

As a result of the overcrowding and increasing demand for inpatient psychiatric services, mental health services are frequently inaccessible to meet the needs of patients and families who seek assistance.

1. Staff in emergency rooms and admission wards readily acknowledged that, under existing circumstances, admission policies and practices had become severely restricted for all patients and usually required a clear manifestation of danger to self or others before admission would be considered. Some clinicians lamented that they were forced to turn away patients who wanted and needed their assistance and who could probably benefit from services, while they admitted other patients with more severe needs who sometimes objected to treatment or had multiple disabilities for which they had no resources to treat.
2. A Commission review of 60 randomly selected patients admitted and discharged by facilities in the New York City metropolitan area revealed that nearly 90 percent had been admitted due to dangerousness to self or others.
3. Commission surveys and field interviews revealed that, in some facilities, fewer than 30 percent of the patients seen in psychiatric emergency rooms were admitted while, statewide, the average admission rate was 45 percent. (Figure 5)
4. With few exceptions, patients denied admission usually received little assistance in finding mental health or other support services elsewhere. Generally, they were given a slip of paper with the name, address and telephone number of an outpatient clinic, but rarely were other forms of assistance provided to assure linkage with appropriate services. Few facilities were able to provide any meaningful follow up to the referral.
5. Families, who are often left to cope with the person in crisis — albeit one deemed not severe enough to overcome the high threshold for admission erected by facilities under stress — are often provided little or no support services.

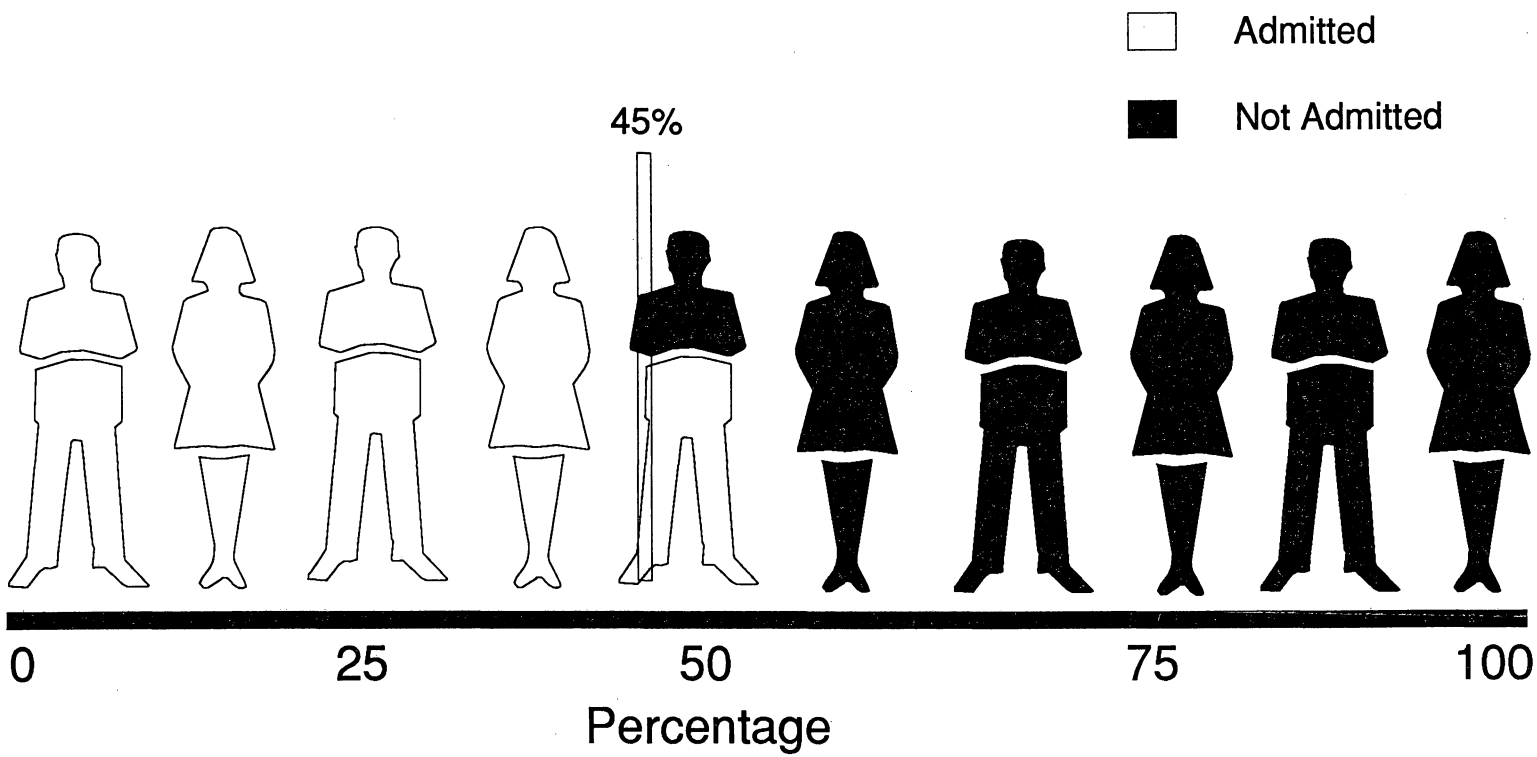
Inappropriate Use of Mental Health Resources

The high demand for inpatient psychiatric care, despite the large supply of beds, is partly due to the "blocking" of a significant proportion of both short-term and long-term psychiatric bed capacity by patients who are no longer in clinical need of inpatient psychiatric care, but who remain because of an absence of suitable alternative care, either within the mental health system or from other human service systems. In some respects, this pattern of the mental health bed utilization is influenced by policy decisions made by other State agencies regarding the supply of Skilled Nursing Facility and Health Related Facility (SNF/HRF) beds and the unavailability of residential and day services to mentally retarded persons living with aging or fragile families. (Figures 6 and 7)

SNF/HRF Beds

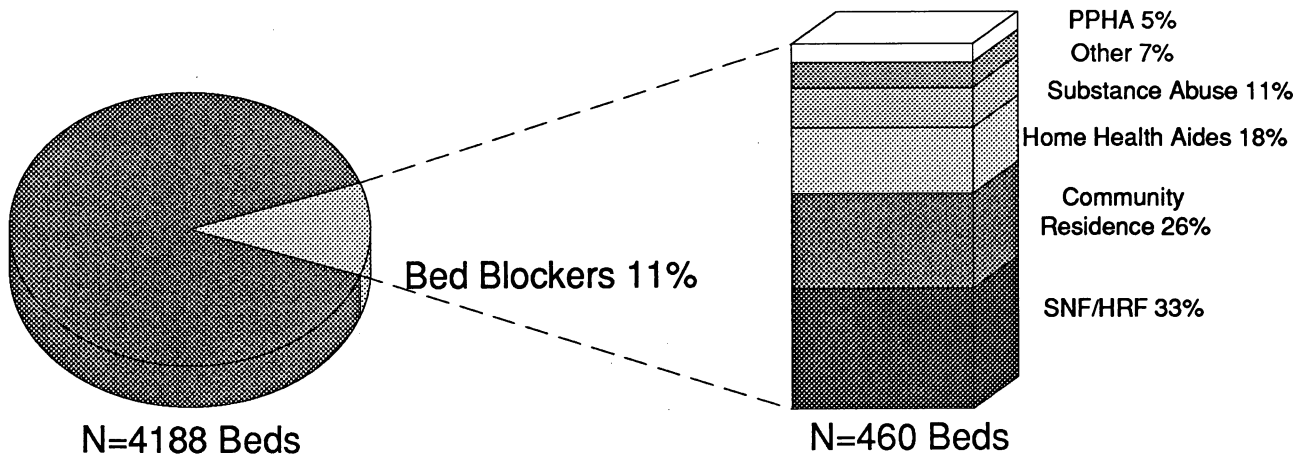
According to the 1988 Update of the OMH 1985-1990 Five Year Plan, one-third of the long-term population of State psychiatric centers, or approximately 5,700 patients, is suitable for a skilled nursing facility level of care. Analysis of data supplied by 77 municipal and voluntary hospitals responding to our mail survey indicates that 11 percent or 460 of their 4188 acute psychiatric beds are "blocked" by patients who are

Figure 5: Percent of Patients Seen for Psychiatric Problems in Hospital Emergency Rooms Who Are Admitted for Inpatient Psychiatric Care*



*Based on Commission indepth interviews at 12 inpatient psychiatric facilities and mail survey responses from 101 of the 135 inpatient psychiatric facilities statewide (Dec., 1987)

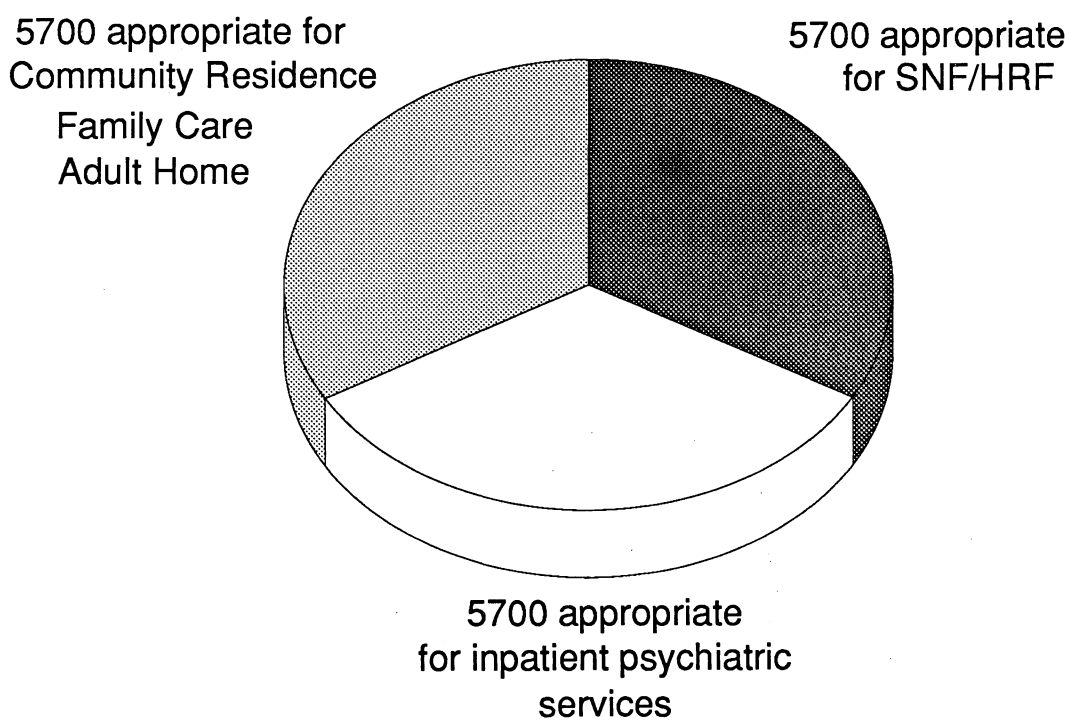
Figure 6: "Bed Blockers" or Persons Occupying Acute Psychiatric Beds Who Require Alternate Levels of Care



*Based on 77 responses of the 109 licensed inpatient psychiatric facilities statewide (December, 1987)

Figure 7:"Bed Blockers" Among Long Term* Stay Patients in State Psychiatric Centers**

Average Annual Cost PC=$59,000
CR+Day Program=$30,000
PPHA/Family Care+Day Program=$18,000



*Approximately 17,100 beds in State Psychiatric Centers are occupied by long term stay patients (i.e., lengths of stay > 90 days)

**Data from the 1985-1990 Five Year Comprehensive Plan for Mental Health Services: 1988 Update and Progress Report. NYS Office of Mental Health, October, 1987.

no longer in need of inpatient psychiatric care and require an alternate level of care. Patients requiring SNF/HRF level of care constituted the largest segment of acute psychiatric care "bed blockers" and occupied 3.6 percent or 150 psychiatric beds of the municipal and voluntary hospitals responding to the survey.

However, restrictions on the development of SNF/HRF beds, coupled with the reported resistance of nursing home operators to accepting mentally ill patients, has made it difficult to discharge patients from psychiatric facilities to these appropriate alternatives.

Mental Retardation Services

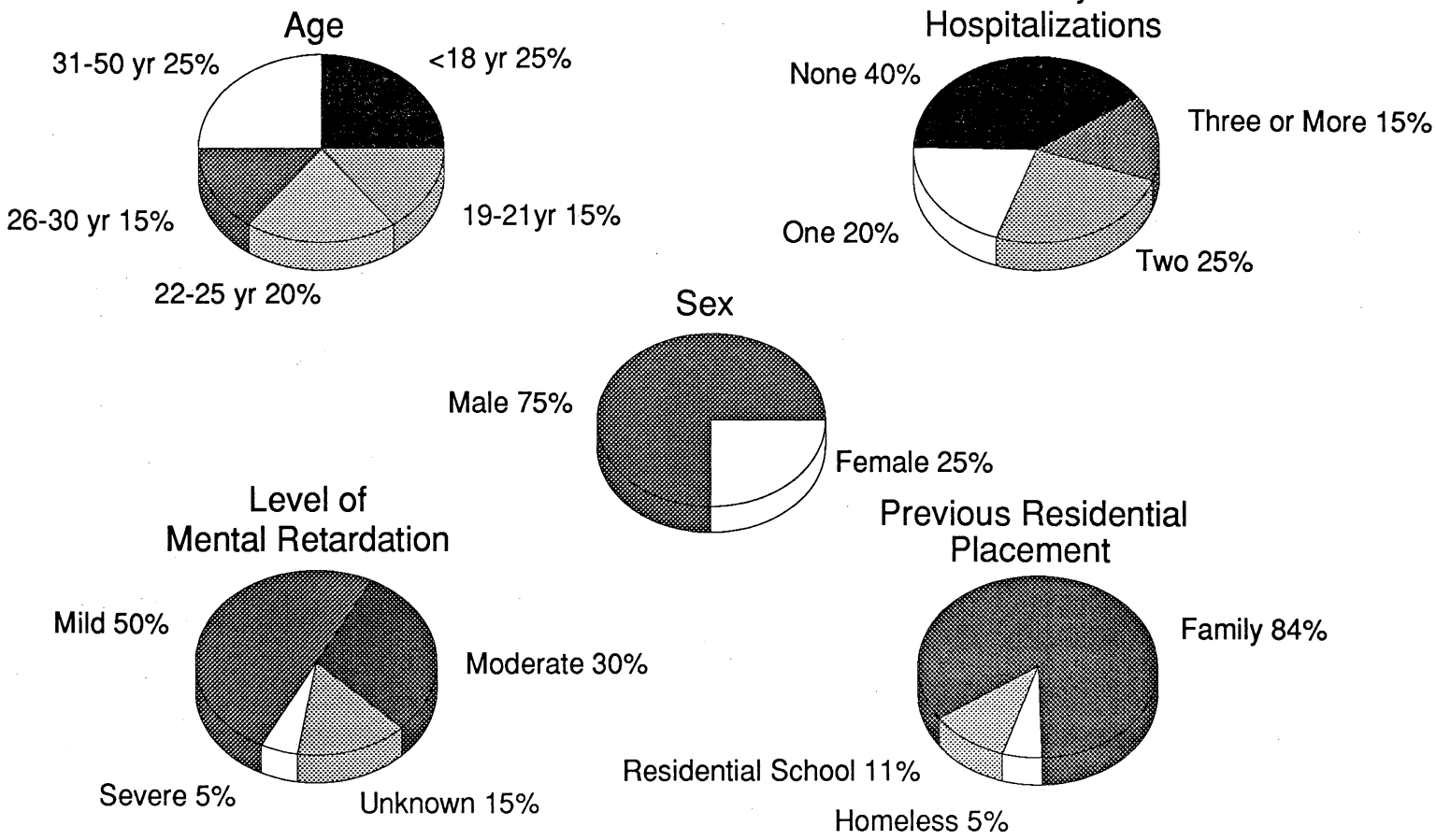
1. According to information provided by OMH, in 1982 there were 800 patients in State psychiatric facilities with a diagnosis of mental retardation who could more appropriately be served in a program for persons with developmental disabilities. While a substantial number of such patients have been transferred to OMRDD Multiple Disability Units in a program that began in 1982, approximately 400 still remain inappropriately served. Nearly half (10 out of 24) of the State psychiatric centers responding to the survey reported that more than five percent of their beds were occupied by persons with a primary or secondary diagnosis of mental retardation. Five of these centers, or 20 percent of the responding State centers, reported that mentally retarded persons constituted 10 to 15 percent of their inpatient populations.

2. According to Health and Hospitals Corporation reports, an estimated 40 patients admitted from the community with a diagnosis of mental retardation are expected to generate 11,000 acute psychiatric hospital days beyond medical necessity in FY 1987 because of difficulty in securing appropriate placements once the crisis which precipitated admission is resolved. This form of inappropriate care is not only expensive (11,000 days @ $500/day = $5.5 million), but effectively denies access to psychiatric hospitalization to 440 mentally ill patients annually (11,000 days / 25 day average length of stay = 440).

3. The Commission's recent follow-up of 20 patients with a diagnosis of mental retardation admitted to acute psychiatric beds in New York City found that these young adults were typically admitted when families could no longer cope with severe aggressive behavior or when one of the family caretakers fell ill or died. Once admitted, these patients proved extremely difficult to discharge and remained in psychiatric facilities for an average of 266 days (high 699 days). (Figures 8 and 9) At an average cost of $500/day, the care of each of these patients cost $133,000 ($500 x 266 days = $133,000). Yet, despite the high cost and long stays, providers frankly admitted their difficulties in providing appropriate services due to the lack of appropriately trained and skilled staff to perform diagnostic assessments or to develop and carry out appropriate treatment plans. Equally troubling, because of these difficulties, some providers indicated an extreme reluctance to admit any patients with a diagnosis of mental retardation for inpatient psychiatric care.

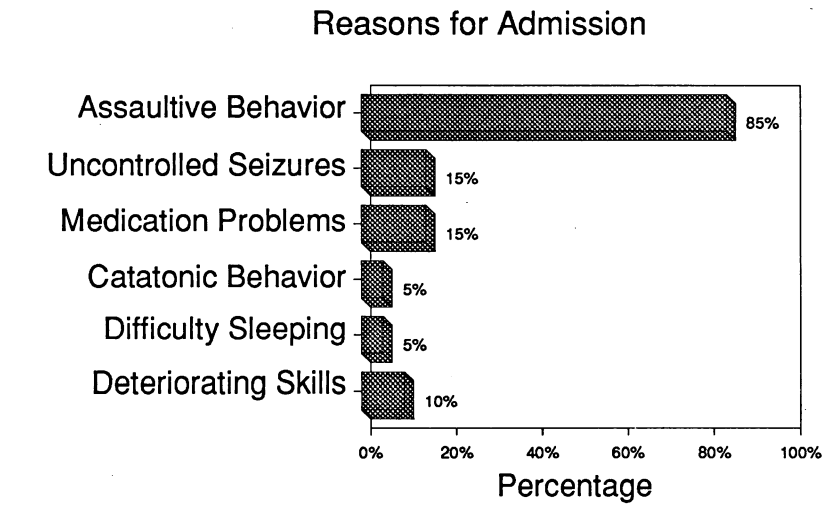
4. Providers uniformly reported that it is extremely difficult to obtain services from the mental retardation system, and particularly residential placements when families were unwilling or unable to continue to care for the patient. While this problem exists in all parts of the State, the slow pace of community residence bed development and the long waiting lists makes the problem particularly acute in New York City. Coupled with existing priorities for available community residential beds generated both by court mandates and internal OMRDD policies to close six developmental centers, including Manhattan and Bronx Developmental Centers,

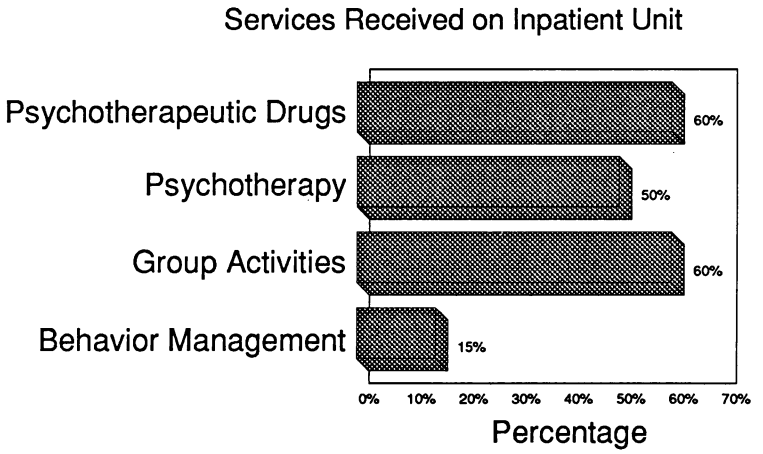
Figure 8: Demographic and Clinical Characteristics of the Sample MH/MR Patients "Blocking Beds" on Inpatient Units in NYC* [N=20]

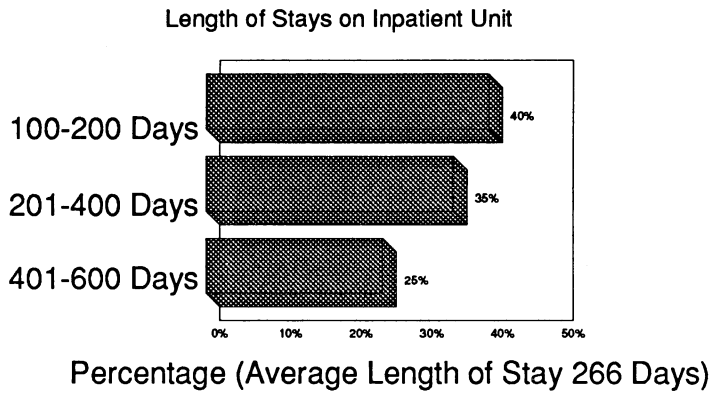


*Based on Commission follow-up study of 20 dually-diagnosed mentally retarded clients in NYC inpatient facilities.

Figure 9:Current Hospitalization Data on the Sample MH/MR "Blocking Beds" on Inpatient Units NYC*







*Based on Commission follow-up study of 20 dually-diagnosed mentally retarded clients in NYC inpatient facilities.

these factors have made it difficult for OMRDD to respond to the needs of mentally retarded patients in licensed and State inpatient psychiatric facilities who require residential care.

5. In a number of cases, there is difficulty in determining the nature of the disability and whether services from OMRDD are indeed warranted. While a dispute resolution mechanism exists to resolve such disputes between OMH and OMRDD, there is little confidence in it because it is ordinarily very time-consuming and yet unsuccessful in resolving disputes and securing necessary services.

Community Placements

According to the OMH Five Year Plan Update, one-third of the long-term patients of State psychiatric centers are similar to individuals residing in community residences, family care homes and adult homes and, presumably, this group of approximately 5,700 patients could live in similar settings were they available. Currently the average annual cost of a State psychiatric center bed is approximately $59,000 — nearly twice the cost of a community residence bed ($30,000) with full-time enrollment in a day treatment program and more than three times the cost of a PPHA or family care placement ($18,000) with full-time day treatment services. However, until recently, the pace of community residential service development had been slow.

In summary, short-term beds are frequently "blocked" by patients awaiting services either in long-term beds in State psychiatric centers or in other service systems. Simultaneously, long-term psychiatric beds are often unavailable to accept transfers because a large number of these beds are "blocked" by patients awaiting community placements or transfers to more appropriate health care facilities. Additionally, the capacity of State psychiatric centers to provide long-term care has been significantly reduced, both through planned census reductions and the increased provision of acute inpatient care.

A considerable portion of the mental health resources are thus devoted to providing a "safety net" for people who are in need of some form of residential services but who have nowhere else to go. Providing this safety net function through inpatient psychiatric hospitalization is enormously expensive, both in dollars and in lost opportunities to serve other persons with mental illness appropriately.

Lack of Community-Based Mental Health Services

The large numbers of persons seen in psychiatric emergency rooms, the high demand for inpatient psychiatric care, and the virtually unanimous pleas from providers for an increase in what is already the largest supply of expensive inpatient psychiatric beds in the country, are symptoms of a system that has not invested sufficiently in developing the quantity and type of community-based support services that could appropriately respond to the needs of people who are mentally ill and their families. Among the services that are needed, but are currently unavailable are:

- supervised community residences, crisis residences, supportive housing and intensive day treatment programs which could reduce or avoid unnecessary inpatient stays;
- case management services to assist patients' negotiation/follow-up with aftercare providers;
- a wider array of outpatient services that respond to the changing needs of the patients served by mental health facilities, including educational and vocational training, skill building in activities of daily living, supported work, drop-in centers, psychosocial programs, and treatment for alcohol and chemical abuse in settings geared towards persons with mental illness;

- flexible family support programs including in-home crisis stabilization services to assist in dealing with psychiatric crises;
- walk-in psychiatric clinics with extended hours, particularly in urban areas, to reduce the demands upon psychiatric emergency rooms for serving patients with less severe needs, and
- twenty-four-hour crisis intervention services, including mobile services to respond to emergencies. In the absence of such services, the police are often called upon to respond to mental health crises. In many communities, adequate training programs are not available to equip the police for this role. While there have been a few highly publicized tragedies resulting from police response to such crises, the more common, but less visible problem is the trauma and stigma to both the mentally ill person and the family in having the police manage these crisis situations, and at times, subdue and handcuff the patient for transport to a psychiatric facility.

More Psychiatric Hospital Beds?

While there has been an increase in the number of acute psychiatric hospital beds in the past decade, the average lengths of stay at many facilities have also increased substantially, thus minimizing the net gain to the system. For example: from 1977-1986, the number of inpatient psychiatric beds in Health and Hospital Corporation facilities increased by 44 percent from 700 to 1,100 beds. But, over the same period, the number of admissions to these facilities decreased 26 percent, from 20,309 in 1977 to 15,068 in 1986, while the average lengths of stay more than doubled from 10.5 days to 23.7 days. The net result was an increase of 143,867 patient days in 1986 as compared to 1977. At an average daily reimbursement rate of $500, these additional patient days cost taxpayers approximately $71.9 million in 1986. (Figure 10)

The increased lengths of stay reflect not only the long stays of mentally retarded patients and geriatric patients in need of SNF/HRF level of care, but also the increasing incidence of multiply disabled patients such as the mentally ill chemical abusers who are difficult to diagnose, treat and discharge appropriately. The OMH Five Year Plan Update indicates that, since 1981, the number of multiply disabled patients with mental illness and substance abuse increased nearly 90 percent, while patients suffering from alcohol abuse and mental illness increased approximately 45 percent.

The longer lengths of stay also reflect the shortage of low income housing and readily available post-discharge residential alternatives like supervised or supportive community residences. Between 1970 and 1980, there was a reduction of 473,000 low income housing units Statewide. In New York City alone, 235,000 low income housing units were lost to gentrification. While the Office of Mental Health certifies and funds approximately 6,000 supervised and supportive community residence beds, hospital staff report frequent delays in finding facilities to which to discharge patients.

A recent survey* of 1,110 Health and Hospitals Corporation inpatients indicated that 202 (18 percent) were no longer in need of inpatient hospitalization. Although discharge planning was in progress for 101 of these patients, the other 101 patients were considered "placement problems" requiring placement in supervised living programs of various types, including skilled nursing and health-related facilities, community residences, residential drug or alcohol treatment programs, PPHAs, etc.

Increasing the number of acute hospital beds without addressing the need for community residential and day services post-discharge is unlikely to change this pattern of service utilization.

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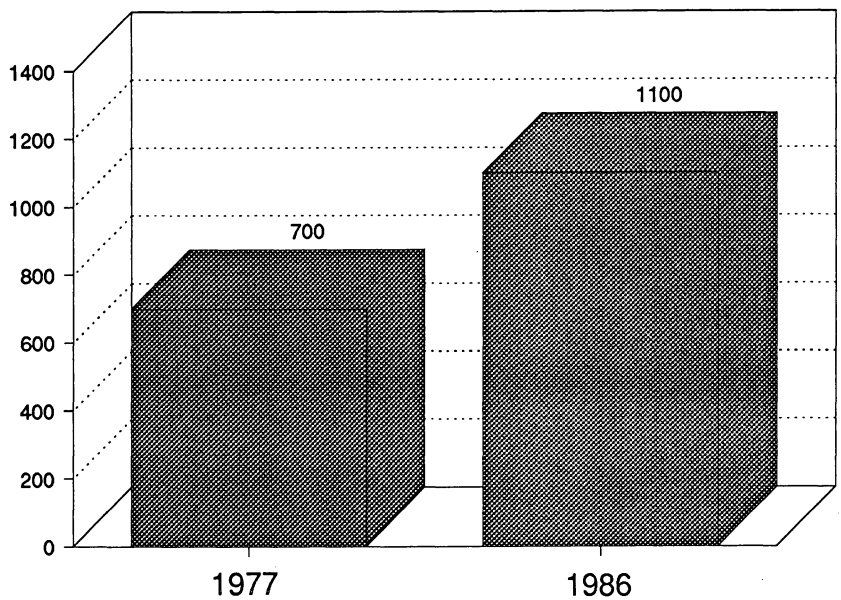
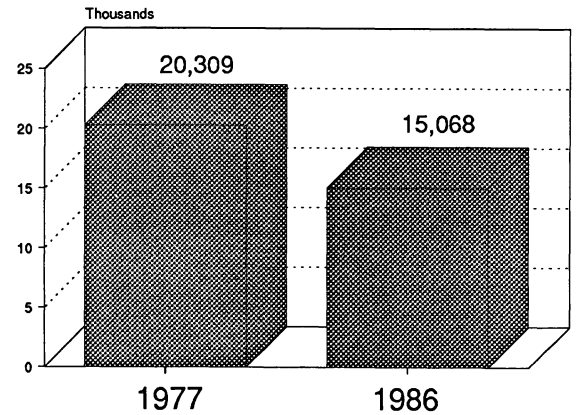
* *Survey of Patients in Residence at Health and Hospitals Corporation Facilities for More than 21 Days*; NYS Office of Mental Health, January 1988.

Figure 10: Health and Hospitals Corporation Beds 1977-1986*

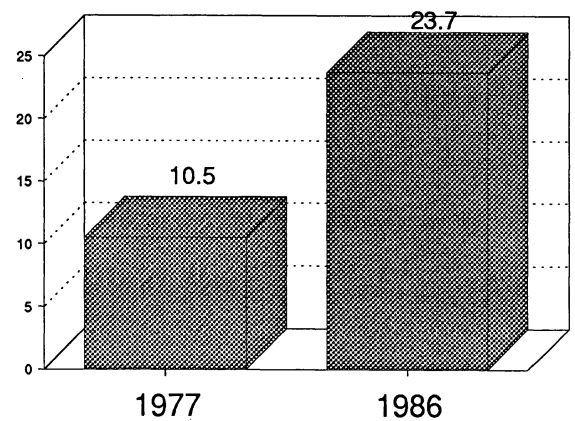
Annual Cost of Increased
Patient Days 1986
=$71.9 million



Beds



Patients Served



Average Length of Stay in Days

*Based on data submitted by the
New York City Health and Hospitals Corporation

Discharge Planning

New York has an extensive statutory and regulatory structure to guide discharge planning. Much of this legal framework was put in place in response to the problems encountered from inadequately planned discharges during the period of deinstitutionalization in the 1960's and early 1970's. Commission interviews with facility staff and our meetings with recipients of services and their families, as well as our follow-up of a random sample of discharged patients, shed valuable light upon discharge practices.

Limitations in Planning and Follow-up

Although our interviews at psychiatric facilities and our review of the 60 discharged patients indicated that patients were usually discharged with planned housing arrangements and at least one other planned aftercare service, other efforts to encourage patient compliance with arranged services were usually not made. For example:

- in only one of 60 discharged cases reviewed was there any documentation that the inpatient facility provided follow-up to ensure that the patient actually received arranged services;
- in only 28 percent of the cases was the patient referred to case management services upon discharge; and
- in 60 percent of the cases, although the patient was referred to an outpatient mental health clinic, he/she did not receive a specific appointment prior to discharge.

Patients also rarely had personal contact with staff of outpatient programs to which they are referred prior to their discharge. Additionally, follow-up by outpatient providers was done in only slightly more than one-third of the cases and, when done, this follow-up was usually limited to trying to contact the patient by phone or letter.

Looking behind the very limited follow-up services extended to this sample of discharged psychiatric patients, the Commission discovered that there was no clear understanding among inpatient or outpatient providers as to their follow-up responsibilities. Moreover, although existing statutes and regulations implicitly place the primary responsibility for follow-up with the discharging inpatient facility, it was apparent that most large urban inpatient facilities, which discharge 1,000-2,000 patients annually, have very limited resources to expend on patient follow-up. Outpatient mental health treatment facilities, on the other hand, view follow-up as discretionary, and at most they see their responsibility as limited to follow-up with patients who fail to keep appointments at their facility. Follow-up for medical, drug/alcohol abuse services, or other services is rarely done. Additionally, the common practice of all facilities of discharging patients with general referrals, rather than specific appointments, further complicates follow-up activities. The failure of licensed psychiatric units of general hospitals to prepare a comprehensive written discharge plan also makes it difficult to assure accountability for implementation of discharge plans. In sum, follow-up on discharged psychiatric patients in most instances appears unlikely to be done effectively.

Lack of Services

A major factor contributing to the deficiencies is the lack of appropriate community-based services. Statewide inpatient psychiatric facilities responding to the Commission's survey reported that many basic needed aftercare services for discharged psychiatric patients were not usually available. Over half of the facilities

reported the periodic or chronic unavailability of supervised residential settings, drug/alcohol abuse services, and/or appropriate day program services (Figure 11)

This lack of services was also plainly evident in our review of the 60 discharged patients, few of whom received intensive outpatient services. Only 17 percent of the sample patients were referred to a supervised residential setting; only 25 percent received day program services in the six months following discharge; and, only 33 percent received any case management services, and in most cases these services were of a very limited nature.

Multiply Disabled

Our review confirmed that the mental health system is serving an increasing number of patients with multiple disabilities, and that these patients are often poorly served. Nearly two-thirds of the 60 discharged patients studied were multiply disabled. Half had drug and/or alcohol abuse problems; 42 percent had medical problems in need of on-going treatment; and, 7 percent were mentally retarded.

The review further showed that nearly 60 percent of the patients with drug/alcohol abuse received *no* referral on discharge to address these needs, and that only 26 percent of these patients actually received drug/alcohol abuse services in the six months following their discharge. Despite the close association of many of the patients' medical disorders (e.g., thyroid problems, diabetes, seizure disorders, etc.) to their psychiatric stabilization, only 20 percent of the patients with medical conditions received a specific appointment for medical care follow-up upon discharge. Thirty-six (36) percent were discharged with no referral, and 44 percent received a referral, but no specific appointment (Figure 12). Similarly, although all four patients who were mentally retarded had been admitted for serious behavioral problems, only half received aftercare referrals which included behavioral management services.

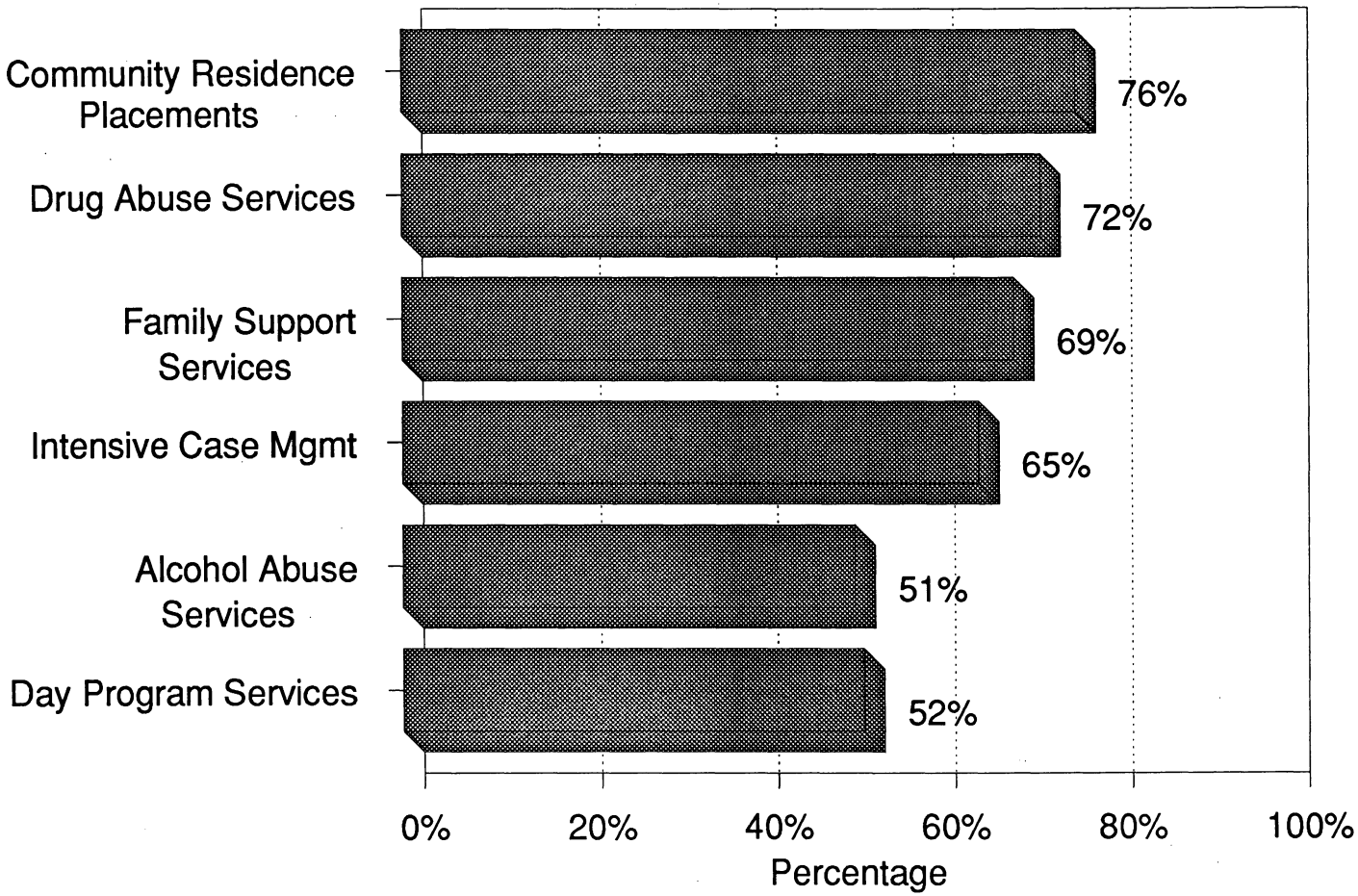
Not surprisingly, given these discharge arrangements, many of the multiply disabled discharged patients encountered problems with their secondary disabilities upon discharge. Half of the patients with drug or alcohol abuse problems continued to abuse these substances upon discharge. Half of the patients with mental retardation were rehospitalized due to continued serious behavior management problems. And, 52 percent of the patients with medical problems experienced a flare-up in their medical conditions in the six months following discharge.

Patient Concerns and Resistance

Patient resistance and non-compliance with services is also reported to be a serious problem. Our review of the 60 discharged patients indicated that half of the patients refused at least one aftercare service referral, and that an additional 23 percent dropped out of at least one service within six months after discharge. As shown in Figure 13, patient resistance and non-compliance with outpatient mental health clinic services was particularly dramatic. Whereas 85 percent of the patients were referred to these services upon discharge, only 35 percent were still regularly attending six months after their discharge. Over one-fourth of the patients never attended the mental health clinics to which they had been referred.

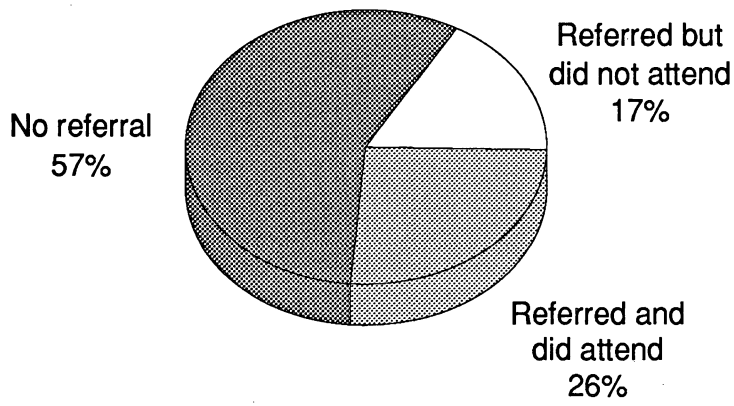
This high refusal and drop-out rate for services has an insidious and costly impact on the service system as a whole. On the one hand, since most outpatient providers are accustomed to high "no show" rates, aggressive follow-up of patients is rarely pursued. On the other hand, cost-efficiently managing a clinic with a 30-40 percent no-show rate is extremely difficult, and tends to lead inevitably either to long patient waits (caused by overscheduling to compensate for estimated "no shows") or under utilization of costly, scarce services. Perhaps most importantly, high refusal and

Figure 11: Percent of Inpatient Psychiatric Facilities Reporting That Outpatient Services Are Not Generally Available*

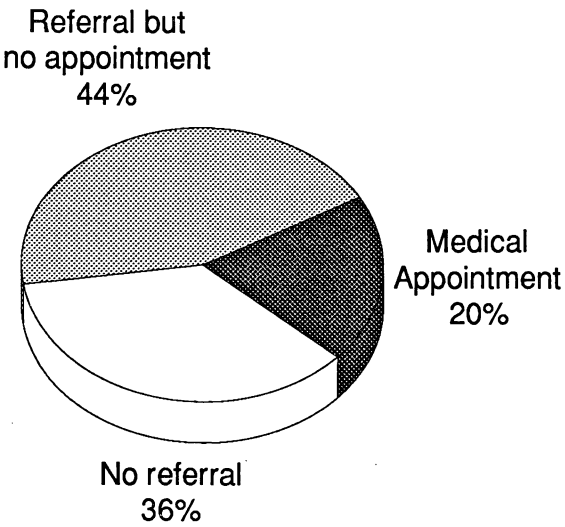


*Based on mail survey responses from 101 of the 135 licensed and State-operated inpatient psychiatric facilities.

Figure 12: Aftercare Referrals and Services by Patients with Multiple Disabilities: Commission Study 1987*



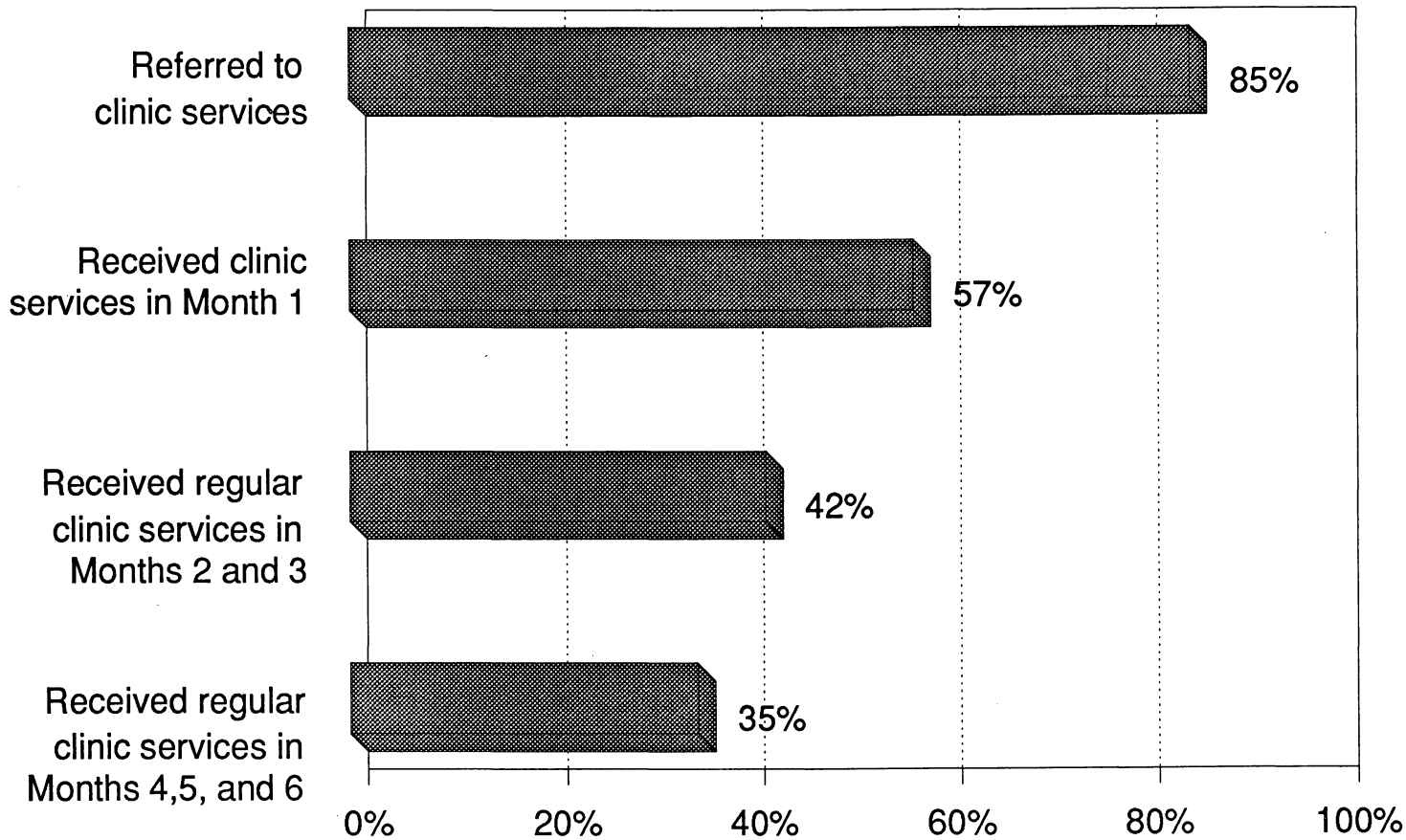
Patients with Drug/Alcohol Abuse Problems (n=30)



Patients with Medical Problems (n=25)

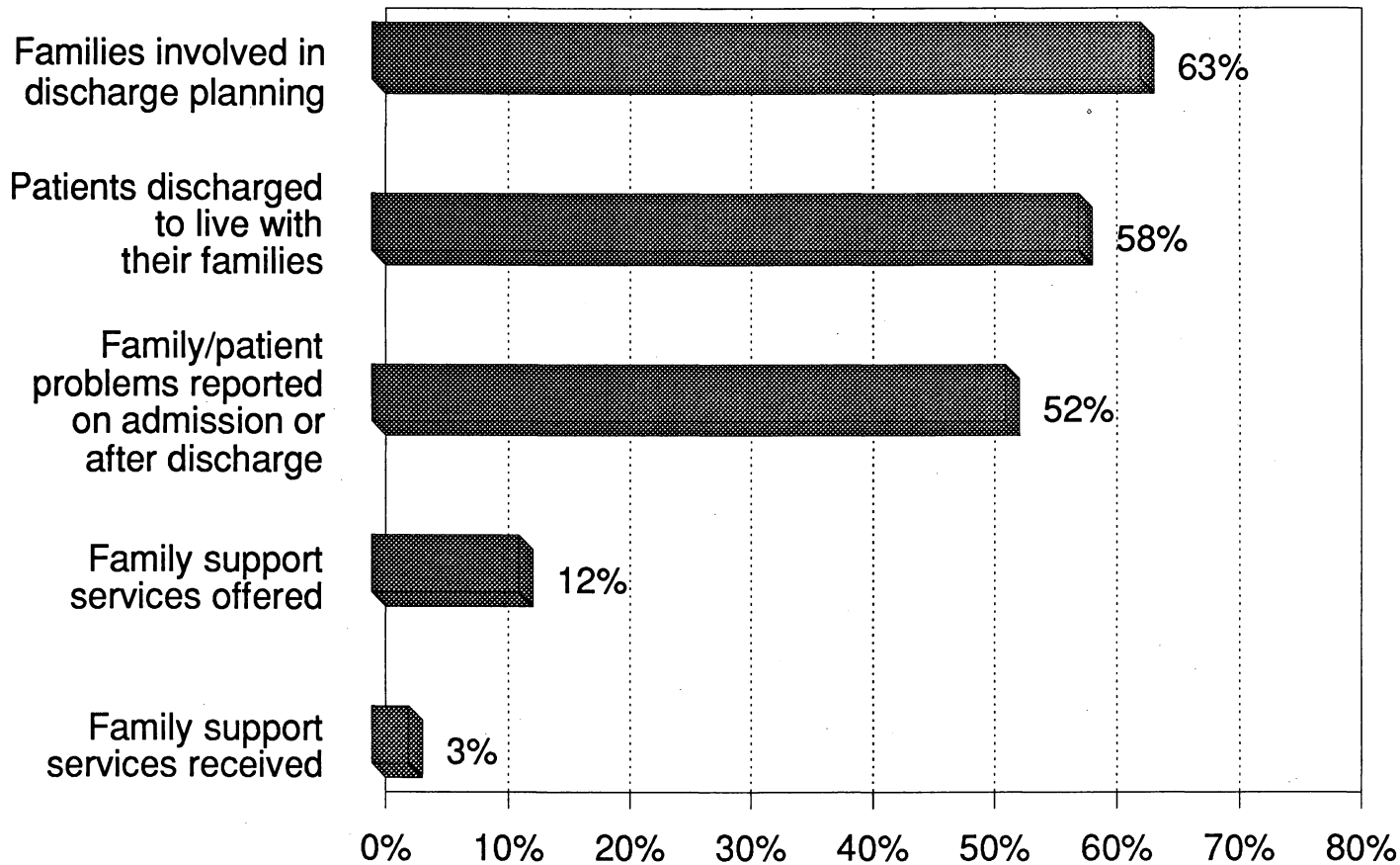
*Based on study of 60 randomly selected patients discharged from five NYC metropolitan area facilities, June, 1987.

Figure 13: Patient Resistance and Non-Compliance with Arranged Mental Health Clinic Services Commission Study 1987*



*Based on study of 60 randomly selected patients discharged from five NYC metropolitan inpatient facilities, June 1987.

Figure 14: Support Roles of Families versus the Availability of Family Support Services Commission Study 1987*



*Based on study of 60 randomly selected patients discharged from five NYC metropolitan inpatient facilities, June 1987.

drop-out rates provide only one more indication that the available array of outpatient services are outmoded and non-responsive to patients' interests and needs, and that New York's outpatient mental health dollars may not be going to the most needed and called-for outpatient services.

Family Involvement

Under pressure to serve other patients awaiting admission, psychiatric facilities often do not have sufficient resources or time to involve patients and family members in discharge planning. Although families are often contacted during discharge planning, these limited contacts rarely allow resolution of known problems in family-patient interactions, and only a fraction of families receive support services after the patient's discharge. Despite this fact, families often provide the primary support for discharged psychiatric patients in New York. For most patients, families, aside from providing the primary housing support for patients, also play the *de facto* roles of case managers and advocates. Research findings also confirm that discharges are generally more successful for patients who have the support and assistance of their families. (Figure 14)

Impact of the Legal System

In addition to the pressures to discharge patients caused by the severe demand for inpatient hospitalization, recent legal developments have created additional incentives to discharge patients.

- In *Savastano v. Nurnberg* (N.Y.L.J., October 1, 1987, at p. 13, col. 3), the State Supreme Court ruled that objecting patients could not be transferred from voluntary or municipal inpatient psychiatric facilities to a State psychiatric center without a judicial hearing. According to several providers in New York City, it currently takes approximately four weeks to schedule such judicial hearings. In addition, they complain about the difficulties in arranging transportation and the clinical and support staff time involved in the judicial process. Thus, unless there are strong clinical contraindications to discharge, there are significant pressures to simply discharge the objecting patient rather than to attempt the transfer. In fact, all three patients who were plaintiffs in this law suit were discharged rather than transferred.

- In *Rivers v. Katz* (67 N.Y. 2d 485, NY Ct of Appeals, June 10, 1986), the New York State Court of Appeals ruled that, except in an emergency, involuntary psychiatric patients may not be treated with psychotropic medications over their objections without a prior judicial determination of incompetence, and approval of the proposed treatment. In New York City, providers of acute psychiatric care report that such judicial proceedings typically take two weeks to schedule and, again, absent strong clinical contraindications, there is a strong temptation to simply discharge objecting patients.

Leaves Without Consent and Escapes

Yet another group of patients discharge themselves by simply walking away from psychiatric facilities each year. Depending on the circumstances, and facility practices, these patients are classified as escapees or as leaves without consent. All of these patients return to the community for varying periods of time without the services they may continue to require. While most eventually return to the facility either voluntarily or through subsequent rehospitalization, 25 percent remain in the community more than 30 days without planned services, and a small number commit suicide upon leaving the facility.

- Each year there are approximately 7,000-7,500 incidents of patient leaves without consent and escapes from State psychiatric centers. Approximately 40 percent of these incidents involve patients who had eloped from the same facility more than once during the year. (See Figure 15)
- Statistics on patient leaves without consent also indicate that incidents of leaves without consent tend to cluster in New York City, Long Island, and upstate urban centers. Centers in these areas account for approximately 85 percent of the total incidents in a given year, while only 15 percent of the total incidents are reported by the other 13 upstate centers. (Figure 16)
- There is also indication that other variables specific to a facility's operation may affect its rate of leaves without consent. For example, the surge in incidents of leaves without consent in 1983 may be attributable to the early retirement program during which many senior and experienced employees left their positions. (Figure 15) Also, the increased number of incidents of leaves without consent at Rockland and Kings Park Psychiatric Centers in recent years may be attributable to their increased provision of acute psychiatric services. (Figure 17)
- While there is little available information about the experiences in the community of patients who leave without consent, available data from State psychiatric centers, indicating that 90 percent of these patients return or are readmitted to the same facility within one year, suggest that few are well-equipped to make successful transitions to community living.
- Death reports filed with the Commission for the period 1984-1986 reveal that 41 patients died shortly after leaving inpatient psychiatric facilities without consent. In all but two of these cases, death was due to an apparent suicide and in 66 percent of the cases, the patient died less than 24 hours after leaving the facility.

Role Confusion

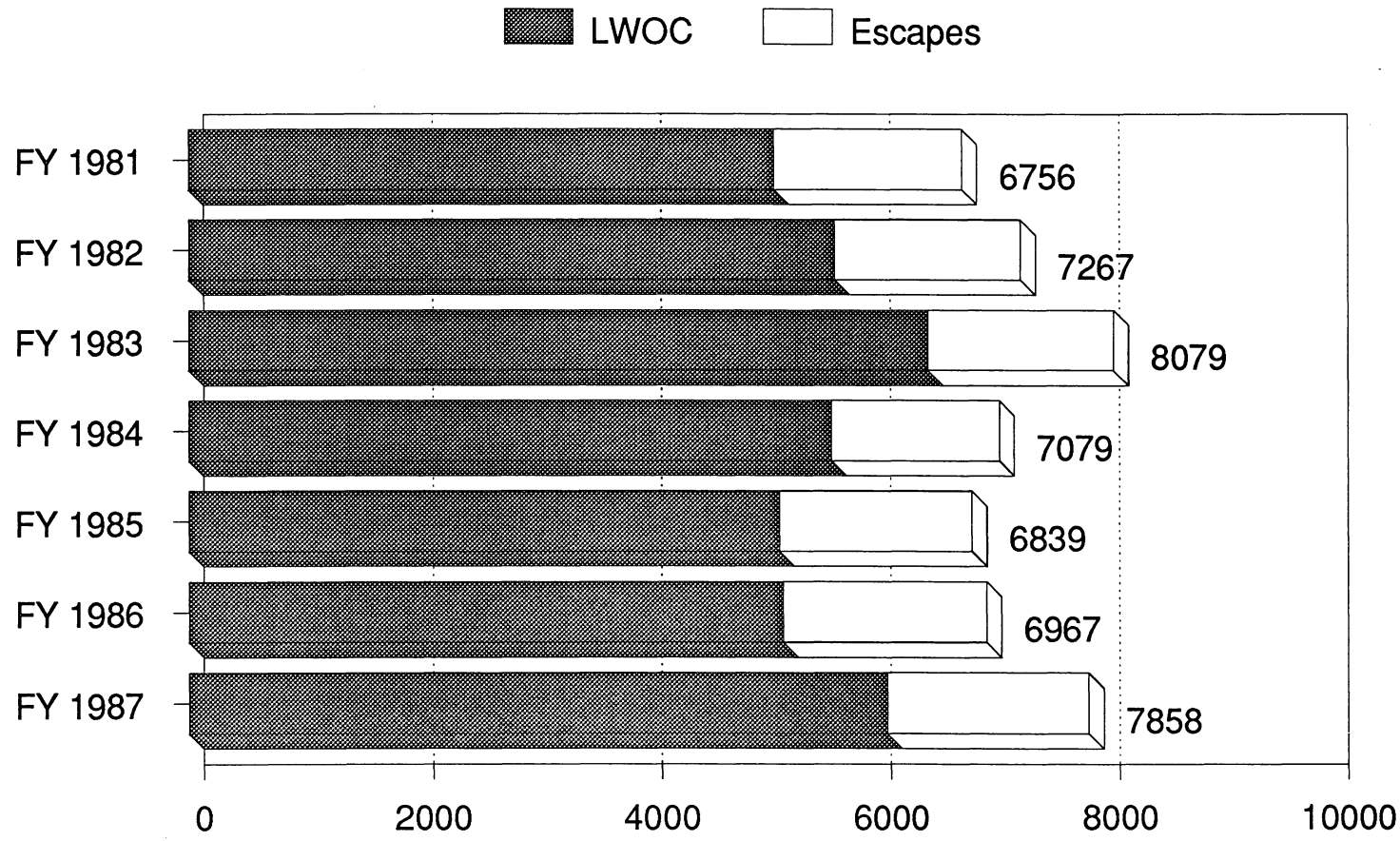
Duplication of and Gaps in Services

The lack of clear role differentiation between State, municipal and voluntary providers of mental health service results in duplicative and overlapping services in some parts of the State (e.g., acute inpatient hospitalization), and severe gaps and shortages in other needed services, particularly for patients with multiple disabilities. This aids in the unplanned and wasteful use of resources by "revolving door" or "high user" patients. These patients, who are variously estimated at between 5 percent and 15 percent of the chronic mentally ill patients served by the system, may go through several hospitalizations in different facilities and receive outpatient services from a variety of programs, with fleeting benefits.

Tripwire Agreements

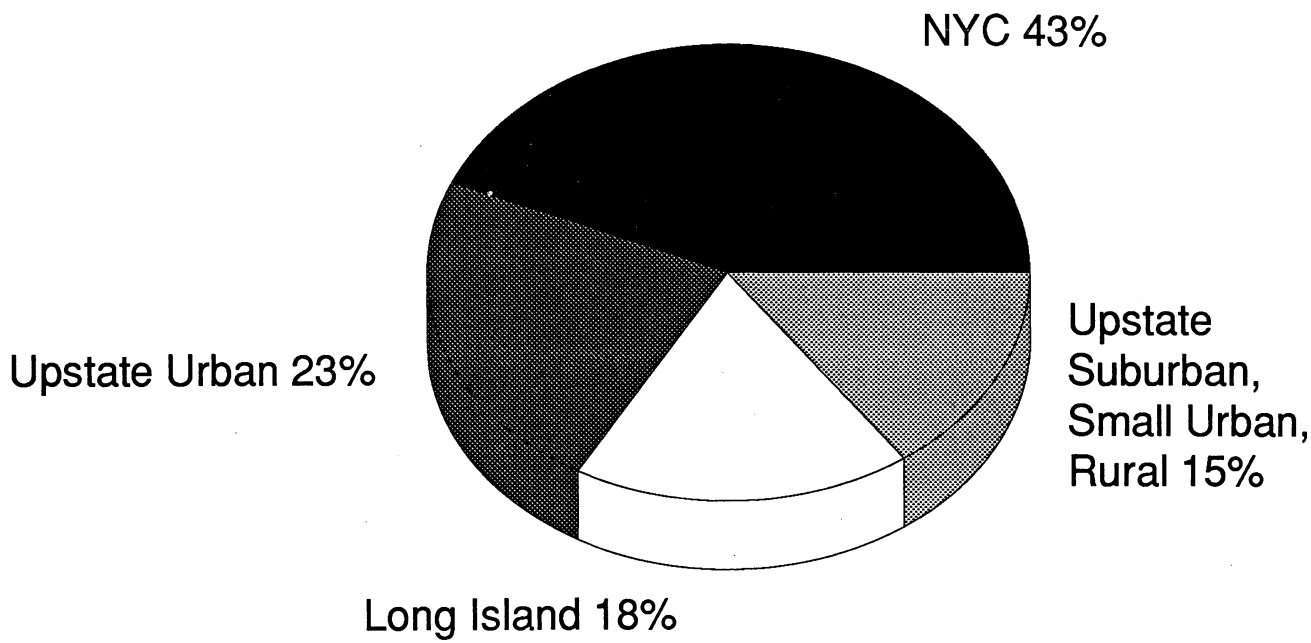
The role confusion of different segments of the mental health provider community has been exacerbated by "tripwire" agreements in New York City, developed to assist acute psychiatric facilities to cope with the surging demand for inpatient hospitalization. Under these agreements, patients are sent directly from psychiatric emergency rooms to State psychiatric centers once the acute facilities are at capacity. Increasingly, State facilities, which are staffed primarily to provide intermediate and long-term care, are becoming providers of acute psychiatric care although they frequently lack the medical care capabilities, the laboratory facilities or the staffing levels of acute care hospitals.

Figure 15: Number of Incidents of Patient Leaves Without Consent/Escapes from State Psychiatric Centers (1981-1987)*



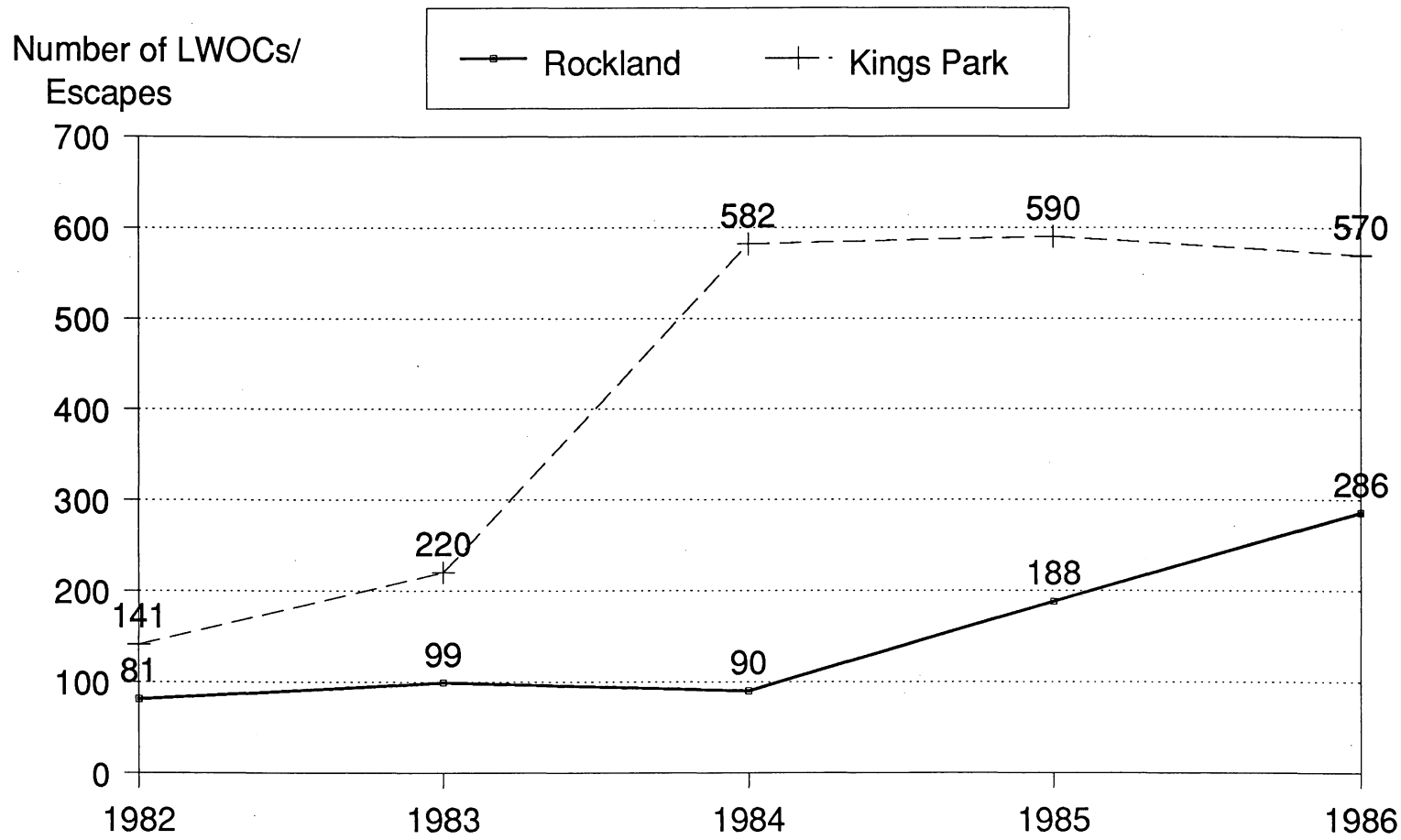
*Based on data obtained from the NYS Office of Mental Health.

Figure 16: Percent of Patient Leaves Without Consent/Escapes from State Psychiatric Centers by Region (FY 1987)*



*Based on data obtained from the NYS Office of Mental Health

Figure 17:LWOC/Escapes Increase with Increased Acute Care Role*



*Based on data obtained from the NYS Office of Mental Health

At the same time, for certain subpopulations of patients, municipal and voluntary hospitals are forced to provide intermediate and even long-term care because of the absence of discharge or transfer options to State psychiatric centers or other long-term care facilities. Hospitals responding to the Commission survey reported that approximately eleven percent of their acute psychiatric beds are occupied by patients who are no longer in need of this level of care but require discharge to a lower level of care or a different type of facility.

None of the segments of the provider community are comfortable with the tripwire agreements.

- State psychiatric centers note that they are ill-equipped to care for acutely mentally ill patients. The transfers of such patients from psychiatric emergency rooms of several hospitals to their wards challenge their limited resources not only in providing appropriate care and services, but in developing discharge plans, which requires establishing working relationships with outpatient service providers in numerous different communities.
- Acute care facilities spend a considerable portion of their staff and resources attempting to transfer and transport patients to other facilities for admission, often without sufficient success to justify the staff time and effort.

Clarify Roles and Responsibilities

There thus appears to be a substantial need for the State Office of Mental Health, local governments, and voluntary providers to devote immediate attention to developing complementary, workable and clearly understood roles and areas of responsibility for each segment of the provider community.

This effort is needed not only for inpatient services, but also for outpatient services where the State now operates:

—21 percent of outpatient clinic programs;
—36 percent of day treatment programs;
—36 percent of continuing treatment programs; and
—29 percent of day training programs.

Voluntary agency providers report that they often appear to be in competition with the State for the same patients, while at the same time large numbers of persons, particularly multiply disabled persons, requiring services appear to be unserved or underserved by both systems.

Outmoded Outpatient Services

In part, this problem of fragmented and intermittent use of services from a variety of providers may be a reflection that the array of available outpatient services has not kept pace with the changing needs of the patients being served. As the OMH Five Year Plan Update indicates, the patients being served by the mental health system are increasingly multiply disabled and younger patients with significant histories of alcohol and drug abuse.

Clinics, day treatment and continuing treatment programs, which comprise 77 percent of all outpatient units of service, may not offer patients the type of services they want or need, or the intensity of staffing required to engage them in treatment. In our meetings with families and with recipients of services, we frequently heard complaints about the "boring" or "irrelevant" day programs to which they were being referred and which they resisted attending.

Instead, recipients and families asked for more vocational and educational programs, supported work opportunities, programs to develop ADL skills, programs to

foster social relationships, and drug and alcohol programs geared to their needs. The types of outpatient services currently and predominantly provided appear to be outmoded for the changing patient population.

Our review also found that although few patients were offered case management services and few families were offered family support services, in over half of these instances, referrals for these purportedly supportive and helpful services were refused, suggesting that either the delivery or the communication of these services to patients and families may be flawed. As New York moves ahead to expand these and other critically-needed outpatient services, it is imperative that patient and family opinions and suggestions for these services be carefully considered.

* * *

CONCLUSIONS

- New York's mental health system is under significant stress due to ever increasing demands for costly inpatient psychiatric services. Most urban hospitals and some non-urban hospitals are overcrowded, with psychiatric patients waiting up to 24-48 hours in emergency rooms for admission evaluations and disposition, and only those patients most critically in need of inpatient psychiatric hospitalizations are eventually admitted.
- Simultaneously, many acute inpatient psychiatric beds in general hospitals and many intermediate and long-term stay beds in State psychiatric centers are occupied by patients who no longer need these intensive and costly services, but who cannot move on to more appropriate, but less costly residential settings because they are unavailable.
- Interim, make-shift remedies to the problems facing inpatient psychiatric facilities, including the tripwire agreement and patient transfers from downstate to upstate facilities, have tended to exacerbate the chaos of the system and its difficulties in providing quality patient care. In particular, these remedies have placed unreasonable demands on several State psychiatric centers to provide substantial acute psychiatric services, although their staffing and resource allocations are geared for intermediate and long-term care.
- Creation of more inpatient psychiatric beds is unlikely to provide any long-term relief for the current crisis or to provide better patient care. More beds are more likely to contribute to the continued inappropriate and overutilization of expensive inpatient services and spiraling costs, and will not guarantee that individuals receive the level of mental health services they require.
- Long-term relief of the current problems facing inpatient psychiatric facilities will be contingent upon the development of a more adequate supply and a more appropriate array of community-based residential and day services for persons with mental illness.
- In developing such services, clarifying the current role confusion between State, local, and voluntary providers, greater involvement of recipients and their families, and a better targeting of resources and services to the most seriously mentally ill and multiply disabled patients who consume a disproportionate share of costly inpatient services, will be critical.

RECOMMENDATIONS

To facilitate the process of achieving needed changes, the Commission offers the following recommendations.

Roles and Responsibilites

1. The Legislature should support the Office of Mental Health's intention to begin, through the State and local planning processes, to develop clearly understood, workable and complementary roles for the State, local and voluntary providers in meeting the needs of persons with mental illness and their families. This process should clearly define State responsibilities and local responsibilities and create a framework for cooperation and shared problem solving.
2. Tripwire agreements whereby acutely mentally ill people are transferred from psychiatric emergency rooms to State hospitals, should be phased out as soon as possible. In the Commission's view, it is generally preferable to foster the transfers of patients from acute inpatient services who require intermediate or long-term care that State facilities are better able to provide. We also believe that permitting acute psychiatric inpatient units to occasionally exceed their capacity in a time of stress is a preferable alternative from the perspective of patient care than transferring acutely ill patients to State psychiatric facilities that are ill-equipped or poorly staffed to respond to their needs.

Community Services

3. In the allocation of State Purposes and Local Assistance funds, priority should be given to developing a core array of mental health services in each locality based upon identified needs. At a minimum, this core of services should include a full array of crisis intervention services, including a mobile response, in-home crisis services, and crisis residences; intensive case management to manage the care of the small group of patients who have historically made repetitive or intensive use of mental health services; and a flexible program of family support services.
4. The Office of Mental Health should re-evaluate the existing array of day services in light of the changing needs of the patients being served, and identify and develop services which respond to these needs, including intensive case management; drug and alcohol treatment programs for mentally ill chemical abusers; walk-in psychiatric clinics with extended hours; vocational, educational and supported work opportunities; psychosocial clubs; and patient-run self-help programs. In this re-evaluation, the Office of Mental Health should specifically examine the availability of funding, including Medicaid funding, for psychiatric rehabilitation programs designed to assist in enhancing the functioning levels of the individuals participating.
5. The Commission is supportive of the Executive Budget recommendations for maintaining the pace of community residential service development.
6. The Commission endorses the recommendations of the New York State Commission on Criminal Justice and the Use of Force regarding training for law enforcement officers to deal with persons with mental illness (May, 1987).

The Elderly

7. The Commission recommends that consideration be given to utilizing unused or excess psychiatric center lands or buildings as a resource to spur development of additional skilled nursing facilities/health-related facilities to meet the needs of large numbers of mentally ill persons who require that level of care.
8. The Commission also recommends that a mechanism be developed to assure access to psychiatric back-up services on demand for patients placed in SNFs or HRFs. We believe such a mechanism would facilitate access to existing beds in these facilities by allaying the fears of operators regarding the management of psychiatric crises.
9. The Commission recommends that consideration be given to developing a program of specially trained home health aides to provide services to geriatric mentally ill persons to facilitate their placement in the community and to enable other such persons to avoid the need for inpatient hospitalization.

The Multiply Disabled

10. The existing dispute resolution mechanism between OMH and OMRDD should be codified, with specific time frames for decision-making and provisions to ensure that decisions are made and implemented to facilitate the provision of appropriate care. In particular, provision needs to be made for resolving impasses between the two agencies.
11. The Commission supports the Executive Budget provisions for the development of three 24-bed units for the care of multiply disabled persons in State psychiatric centers, as well as for the creation of joint OMH/OMRDD multi-disciplinary mobile teams. In addition, we suggest the development of regional crisis residence beds for dually diagnosed mentally retarded clients in the community to avoid unnecessary and lengthy inpatient psychiatric hospitalizations.
12. The Commission supports significant additional funding for program development for mentally ill chemical abusers, both on an inpatient and outpatient basis.

Enhancing Discharge Planning

13. To facilitate the transition of patients from inpatient to outpatient services, we recommend that the first outpatient visit of the patient to the program or the program staff to the facility occur prior to the actual discharge of the patient.
14. The Commission recommends that the roles and responsibilities of inpatient and outpatient mental health facilities in following-up on discharged patients be clarified. Current statutes and regulations which implicity place the primary responsibility for follow-up on inpatient facilities appear neither to be working nor to be workable. Consideration should be given to assigning inpatient facilities more limited responsibilities for ensuring initial patient contact with the primary mental health provider and to assigning the primary community-based mental health provider responsibilities, as well as adequate resources, for subsequent follow-up with the patient.
15. To remove other barriers to appropriate patient follow-up, all inpatient psychiatric facilities should be required (absent a legitimate clinical rationale) to provide patients with a specific appointment with their primary mental health outpatient provider prior to discharge, and to provide this provider with a comprehensive listing of other arranged aftercare service referrals for the patient within five working days of his/her discharge.

APPENDIX A

Responses to Commission's Preliminary Draft Report on Admission and Discharge Practices

NEW YORK STATE
OFFICE OF MENTAL HEALTH 44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

February 18, 1988

Clarence J. Sundram, Chairman
Commission on Quality of Care
99 Washington Avenue, Suite 1002
Albany, New York 12210

Dear Chairman Sundram:

I have read with great interest the preliminary report summarizing the Commission on Quality of Care's study of the admission and discharge practices of our psychiatric center. The report highlights several key factors which currently impede the movement of patients through the continuum of services.

As the Commission's report points out, the Office of Mental Health's approach to addressing these factors must be two pronged. First, we must prudently use the resources currently available to us and clarify our role and responsibilities with other state agencies, local governments and the voluntary providers. Secondly, the Office of Mental Health must develop innovative programs which are responsive to the needs of the chronic patients who utilize a large portion of intensive services. I trust the attached responses to the Commission's recommendations will reflect the actions being taken to address these issues.

I would also like to thank the Commission for its support and advocacy on behalf of the Office of Mental Health. This advocacy is particularly crucial to OMH as we engage other agencies in the process of clarifying their roles as human services providers, including the treatment of the mentally ill.

I look forward to a cooperative relationship with the Commission as we work together to achieve our mutual goal of improved services to the mentally ill.

Sincerely,

Richard C. Surles, Ph.D.
Commissioner

Attachments

cc: Bruce Feig
Alice Lin
Pat Campbell
Johanna Ferman, M.D.
Anne O'Sullivan
John Petrila
C. Richard Orndoff
Bryan Rudes
William Morris
Ella Curry
John Iafrate, M.D.
Marcia Fazio
Noreen Fisk
Donna Baker
Ann Booughtin
Barbara Soldano
Sarah Rose
Robert Myers
Joel Dvoskin
Cynthia Feiden-Warsh
Mike Labate

OMH RESPONSE TO RECOMMENDATIONS
ADMISSION AND DISCHARGE PRACTICES OF PSYCHIATRIC HOSPITALS
JANUARY 1988

RECOMMENDATION #1:

The Legislature should support the Office of Mental Health's intention to begin, through the State and local planning processes, to develop clearly understood, workable and complementary roles for the State, local and voluntary providers in meeting the needs of persons with mental illness and their families. This process should clearly define State responsibilities and local responsibilities and create a framework for cooperation and shared problem solving.

RESPONSE:

The Office of Mental Health has made major strides in uniting the process of planning for state and locally provided programs. The 1988-89 planning process will require the State psychiatric center and locality to work together to identify the individuals most in need of mental health services. OMH will identify general characteristics of the target population for this process.

In addition, the 1988-89 Local Governmental Plan calls for jointly developed displays of the existing service structure, the plans for services through 1991, and a service plan for the next fiscal year. In this way, OMH is continuing to reduce service barriers created by unclear roles and responsibilities.

OMH has also more clearly defined the role of the State psychiatric center as the provider of long term care with the municipal hospital system and general hospital system responsible for the acute care inpatient needs of the mentally ill. The acute bed need methodology established by the OMH provides the framework within which this delegation of responsibility can be implemented.

Finally, OMH has identified as a priority the development of community based services to occur in the local sector whenever possible. Through the proposed 1988-89 local planning process, OMH is providing maximum flexibility for localities to identify and develop plans for treating the individuals in need of service in their area. OMH in return is committed to negotiating for the resources and then working closely with the locality to assure the provision of the approved services. We believe this process provides workable and complementary roles for the State, local and voluntary providers.

RECOMMENDATION #2:

Tripwire agreements whereby acutely mentally ill people are transferred from psychiatric emergency rooms to State Hospitals, should be phased out as soon as possible. In the Commissioner's view, it is generally preferable to foster the transfers of patients from acute inpatient services who require intermediate or long-term care that State facilities are better able to provide. We also believe that permitting acute psychiatric inpatient units to occasionally exceed their capacity in a time of stress is a preferable alternative from the perspective of patient care than transferring acutely ill patients to State psychiatric facilities that are ill-equipped or staffed to respond to their needs.

RESPONSE:

The Office of Mental Health concurs that the current tripwire agreements are not long-term viable options for addressing the needs of acute patients. Through recent legislation and new targeted initiatives, OMH is making inroads with psychiatric emergency rooms and general hospitals to accept the responsibility for acute psychiatric services.

The passage of Chapter 409 of the Laws of 1987 requires all general hospitals with psychiatric units to accept emergency patients. The implementation of this legislation recognizes that the ability to admit patients on an involuntary emergency status is an integral part of the continuum of care. It is anticipated that this legislation will result in making available additional beds for involuntary emergency patients within the general hospital system.

In cooperation with the New York City Department of Mental Health (NYCDMH) and the Health and Hospitals Corporation (HHC) the Office of Mental Health recently concluded a survey of patients in residence at HHC hospitals for more than 21 days. The intent of this survey was to assess why some HHC psychiatric beds are "clogged"; to what extent difficulties in transferring patients to the intermediate level of care in State psychiatric centers accounted for problems in clogging the system; and, to develop a data base for use in enlisting other agencies, such as the Office of Mental Retardation and Developmental Disabilities, in facilitating placement of patients in non-mental health settings. This survey has been very beneficial in providing solid data which has focused efforts in moving patients through the continuum of services to the level of care appropriate with their needs.

The Office of Mental Health, in conjunction with the New York City Department of Mental Health has organized a team whose goal will be, within 45 days, to move 100 patient from acute

settings within the HHC and major voluntary hospitals to more appropriate levels of care within State psychiatric center or to placements outside of the OMH system.

The new Intensive Case Management initiative will also impact upon the acute psychiatric system. The target group of patients to be served are those individuals who account for a disproportionate percent of the emergency services delivered. The Intensive Care Managers, will receive specialized training, and will be responsible for a small case load consisting of approximately 10 patients 24 hours a day. This innovative approach to case management will divert admissions to the acute psychiatric system by diffusing most crises before the patient gets through the emergency room doors.

RECOMMENDATION #3:

In the allocation of State Purposes and Local Assistance funds, priority should be given to developing a core array of mental health services in each locality based upon identified needs. At a minimum, this core of services should include a full array of crisis intervention services, including a mobile response, in-home crisis services, and crisis residences; intensive case management to manage the care of the small group of patients who have historically made repetitive or intensive use of mental health services; and a flexible program of family support services.

RESPONSE:

The policy of OMH is to develop a comprehensive integrated system of treatment and rehabilitative services for the mentally ill. To accomplish this task, OMH will plan with local governments, voluntary agencies and all providers and consumers to develop an effective, integrated, comprehensive system for the delivery of all services to ensure that appropriate care, treatment and rehabilitation is provided to the mentally ill close to their communities. OMH in accomplishing this policy will focus its efforts on those people most in need, that is, those individuals who as result of the severity and chronicity of their illness, their socio-economic status and absence or diminished natural support system, require mental health systems interventions in order to be maintained or returned to an appropriate level of community functioning.

To accomplish this, it is necessary to identify those populations who have needs that are not presently being met through the existing mental health system. In addition, it is essential to identify those parts of the mental health system that are essential to provide a full continuum of services as well as continuity of care for these populations with the

greatest need.

To accomplish this task, OMH has designated Core Functions, a total of five in all, designed to capture the services and programs necessary to provide appropriate care for people during all phases of their mental illness. The 1988-89 Local Plan Guidelines requests that each locality identify under which programs they currently provide or plan to provide each of the major Core Functions for each population. These functions include:

- Intensive Case Management
- 24 Hour Emergency Crisis Services
- Rehabilitation/Treatment Services
- Residential Services
- Support Services

and will be used as the framework within which localities will describe their existing system of service and their needs for additional services.

RECOMMENDATION #4:

The Office of Mental Health should re-evaluate the existing array of day services in light of the changing needs of the patients being served, and identify and develop services which respond to these needs, including intensive case management; drug and alcohol treatment programs for mentally ill chemical abusers; walk-in psychiatric clinics with extended hours; vocational, educational and work supported opportunities; psychosocial clubs; and patient-run self-help programs.

RESPONSE:

The OMH continues to re-evaluate the existing array of day services in light of the changing need and mission of OMH. Towards this end, OMH is engaging in:

- o development of new and different service modalities and service type programs including intensive case management programs for mentally ill chemical abusers and alcoholic mentally ill individuals, and multi-disabled.

- o OMH continues its efforts at developing innovative models for vocational, educational and work supported programs.

- o OMH is pursuing the patient operated and self-help program models which will include greater emphasis and more focused attention on the patient managed and

developed programming.

- o OMH is establishing a workgroup to review the New York State Codes, Rules and Regulations, Title 14, Parts 579 and 585 which provide the guidelines for the major out patient programs operated by the OMH: clinic treatment, day treatment, continuing treatment and day training.

RECOMMENDATION #5:

The Commission is supportive of the Executive Budget recommendations for maintaining the pace of community residential service development.

RESPONSE:

The OMH Ten-Year Plan bed development goals, as expressed in the proposed Executive Budget, is to create a community residential system comprised of 13,000 community residence (CR) and 3,000 Residential Care Centers for Adults (RCCA) beds by the end of fiscal year (FY) 1995-96. Current development plans indicate that 932 CR beds will open in FY 1987-88, 1,159 in FY 1988-89 and 1,200 in FY 1989-90. For RCCAs, development plans for 366 beds to open in FY 1987-88, 180 in FY 1988-89 and 764 in 1989-90. Four hundred twenty-three CR beds and 101 RCCA beds have opened to date in FY 1987-88. Continued development authority for approximately 1,200 CR and RCCA beds will be requested annually by OMH to ensure that our Ten-Year Plan development goal is realized.

RECOMMENDATION #6:

In addition, the Commission recommends that consideration be given to utilizing unused or excess psychiatric center lands or buildings as a resource to spur development of additional skilled nursing facilities/health-related facilities to meet the needs of large numbers of mentally ill persons who require that level of care.

RESPONSE:

Office of Mental Health agrees that the utilization of unused or short-term psychiatric center buildings and grounds have strong potential for skilled-nursing/health-related facilities development. This is particularly appropo as it relates to the importance to psychiatric centers of having co-located programs which are compatible. Geriatric housing of any type would clearly be looked upon favorably by our hospital

administrations.

Currently, the Office of Mental Health is working in conjunction with the Office of General Services, the Office for the Aging, and the Urban Development Corporation to develop a substantial elderly housing project at the Pilgrim Psychiatric Center. At Rockland Psychiatric Center there is also great potential to further this goal. As census rundown continues to reflect the implementation of alternative residence development a significant number of inpatient structures statewide will become available. The Office of Mental Health stands ready to work with other state, federal and local agencies in the implementation of this initiative.

RECOMMENDATION #7

The Commission also recommends that a mechanism be developed to assure access to psychiatric back-up services on demand for patients placed in SNFs or HRFs. We believe such a mechanism would facilitate access to existing beds in these facilities by allaying the fears of operators regarding the management of psychiatric crises.

RESPONSE:

In accordance with existing policy, the Office of Mental Health continues to assume the primary responsibility for readmitting all patients, including those discharged to SNFs and HRFs, within 90 days if it is clinically appropriate. However, OMH concurs that this responsibility needs to be clearly defined and articulated to operators of SNFs and HRFs.

OMH also provides through their mobile geriatric teams consultative and preventative services to SNFs and HRFs. These services have been beneficial to both the psychiatric centers and operators in ensuring the stability of patient's placement and in the sharing of expertise in the management of psychiatric crisis.

OMH will continue to enhance and expand its relationships with SNFs and HRFs to develop further discharge options for our extended care patients.

RECOMMENDATION # 8

The Commission recommends that consideration be given to developing a program of specially trained home health aides to provide services to geriatric mentally ill persons to facilitate their placement in the community and to enable other such persons to avoid the need for inpatient hospitalization.

RESPONSE:

OMH concurs there is a need for home health aides who have been specifically trained to work with the mentally ill. The identification and inclusion of content relevant to the elderly mentally ill and/or MICAAs should be a priority for those responsible for training these workers. The Office of Mental Health will engage the Departments of Health and Social Services in discussions focusing on developing a psychiatric component for home health aide and home attendant training.

Currently, there are Personal Care providers, who work primarily with geriatric patients, as a component of our Family Care Programs. In the Personal Care Model, family care providers function much like home health aides and have developed an expertise in working with the mentally ill on such issues as daily living skills and personal hygiene. This resource is available to any mentally ill patient who requires this level of care through a referral to the Family Care Program operated by each of OMHs psychiatric centers.

RECOMMENDATION #9:

The existing dispute resolution mechanism between OMH and OMRDD should be codified, with specific time frames for decision-making and provisions to ensure that decisions are made and implemented to facilitate the provision of appropriate care. In particular, provision needs to be made for resolving impasses between the two agencies.

RESPONSE:

A new Interagency Agreement is being developed between the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD) on providing services to multi-disabled individuals with a developmental disability and mental illness. The proposed agreement requires the development of County Services Plans for the multi-disabled which will include:

- A mechanism to provide crisis intervention and stabilization in the client's residential setting.
- Short-term crisis residential capacity to allow for placement of the client for a brief period, if necessary.
- Joint screening and consultation.
- Case management to link clients with appropriate service providers.

- A process for accessing inpatient psychiatric care for short-term stabilization.

- Procedures for returning a patient to his/her original residential setting following hospitalization.

- Dispute resolution procedures for resolving agency differences concerning responsibility for patients and other disputes regarding compliance with the terms of the Interagency Agreement.

The Interagency Agreement also proposed the establishment of regional committees on the multi-disabled with OMH and OMRDD representation to resolve issues that cannot be settled at the local level. Specific time frames will be established in the Agreement for resolving disputes concerning primary responsibility (10 working days) and returning individuals to residential settings after psychiatric stabilization (5 working days). OMH believes that this agreement will significantly improve the coordination of services between the two service systems.

RECOMMENDATION #10:

The Commission supports the Executive Budget provisions for the development of three 24-bed units for the care of multiply disabled persons in State psychiatric centers, as well as for the creation of joint OMH/OMRDD multi-disciplinary mobile teams. In addition, we suggest the development of regional crisis residence beds for dually diagnosed mentally retarded clients in the community to avoid unnecessary and lengthy inpatient psychiatric hospitalization.

RESPONSE:

OMH considers the development of three 24-bed units for the care of the multi-disabled in State psychiatric centers, as proposed in the Executive Budget, crucial for the provision of an appropriate level of care for this patient group. The success of OMH's only current existing unit at Mohawk Valley Psychiatric Center indicates that with the sufficient staff, behavior management techniques and programs, this patient group demonstrates significant potential for placement in less restrictive residential settings. Additional units of this type will ensure that more individuals receive appropriate care and reduce the waiting list for placement in the Mohawk Valley Psychiatric Center Multi-Disabled Unit.

OMH and OMRDD are currently negotiating a revised Cooperative Agreement for Services to Multi-Disabled Persons.

The purpose of this agreement will be to develop a comprehensive range of services to sustain multi-disabled patients in community settings, and thus avoid unnecessary and costly inpatient psychiatric hospitalization. Among other things, this agreement will require each county, in conjunction with the corresponding psychiatric and developmental center, to develop a full range of services for the community based multi-disabled group including access to inpatient care, joint screening and consultation, case management, emergency stabilization, both short and long term crisis services and access to appropriate residential options.

RECOMMENDATION #11

The Commission supports significant additional funding for program development for mentally ill chemical abusers, both on an inpatient and outpatient basis.

RESPONSE:

Staff in the Bureau of Program Development have been working with the Task Force on Integrated Projects to develop both inpatient and outpatient programs for MICAAs, The Task Force allocated funds from the ADTR Block Grant to local providers who submitted applications for treatment and prevention/education programs under an RFP released in November 1987. Thirty-three prevention and ten treatment programs were funded. An additional $5.7 million dollars has been recommended in the Governor's Budget for FY 88-89. OMH, SED, DSAS, and DAAA jointly make decisions regarding program development under this allocation.

In FY 88-89, CSS dollars will be targeted to service for the homeless mentally ill and minorities, a portion of whom will be mentally ill chemical abusers. In allocating these funds, OMH will use a contractual process with providers to encourage them to serve patients with more complex needs.

RECOMMENDATION #12:

To facilitate the transition of patients from inpatient to outpatient services, we recommend that the first outpatient visit of the patient to the program or the program staff to the facility occur prior to the actual discharge of the patient.

RESPONSE:

The Office of Mental Health recognizes the importance of providing its patients with a sense of continuity of services as they move from inpatient to outpatient services. One of OMH's initiatives which addresses this issue is the development of the Community Preparation Program. The Community Preparation Program

is a unit or units within each psychiatric center which provides extended care patients with an environment focused on enhancing their readiness for community placement. An integral part of the Community Preparation Program is the emphasis it puts on staff closely interfacing with outpatient services providers and following patients as they transition to the community. For example, a patient is scheduled to enter a community residence. Prior to this transition, staff from the community residence may visit with the patient in the Community Preparation Program, or the patient, accompanied by a staff, may go to dinner or participate in activities at the community residence. The same process would be in place for patients entering a day treatment program, or vocational program.

OMH will continue its efforts in ensuring patients' transition to the community are done in a supportive and orderly fashion. Experience has demonstrated discharges require careful planning and close monitoring of the patient's needs to be successful.

RECOMMENDATION #13:

The Commission endorses the recommendations of the New York State Commission on Criminal Justice and the Use of Force regarding training for law enforcement officers to deal with persons with mental illness (May 1987).

RESPONSE:

During 1987, the Office of Mental Health and the New York State Division of Criminal Justice Services, Bureau for Municipal Police, in conjunction with Ulster County Mental Health Services and a Statewide Advisory Committee, initiated the development of a training program designed to assist basic recruit level law enforcement officers in identifying and safely managing emotionally disturbed persons in the community. This program was pilot tested in two sites (Corning and Syracuse) in November and December 1987. Final pilot testing and completion of the curriculum are planned for the summer of 1988.

Thanks to the strong advocacy of the Bureau of Municipal Police (DCJS), this project will result in every police officer in New York State's over 600 police departments receiving at least nine high quality hours of didactic and experiential training in dealing with mentally ill citizens.

STATE OF NEW YORK
OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES

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(518) 473-1997

ARTHUR Y. WEBB
Commissioner

February 22, 1988

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

Thank you for sharing your preliminary findings and recommendations regarding admission and discharge practices of facilities providing inpatient psychiatric services. While the report mainly focuses on needs within the mental health system, developmentally disabled people with a mental health disorder represent comparatively small numbers of people, but significant issues. Overall, the report presents an issue which affects all state agencies responsible for the care of individuals and families in need—a seemingly unlimited demand for services and a finite supply of services with which to respond.

A common problem which is shared by OMRDD and OMH is the limited availability of community beds, especially in New York City. I recently submitted a report to the Legislature (attached) which highlights the crisis of availability of residential services. In New York City alone, more than 3,500 individuals are in need of out-of-home placement.

OMRDD seeks to significantly increase the pace of New York City community residential development over the next several years. The goal is to reach 1,000 new community beds per year. That development will be possible, in part, because funds will be redirected from closing developmental centers. During the same period, between 300 and 400 beds in non-closing NYC developmental centers will become available for new admissions, as OMRDD completes the court mandated placement of Willowbrook Class Clients.

In addition to clients needing community residential accommodations, there are clearly individuals in State psychiatric facilities with a diagnosis of mental retardation who could be served more appropriately in an OMRDD program. Over the past several years, OMH and OMRDD have made considerable progress toward transferring these individuals.

The information presented on pages 9 and 12 of the report understates the magnitude of OMRDD's efforts in admitting people from OMH psychiatric centers. Since OMRDD was established, we have admitted more than 1,000 people from State

psychiatric centers. Almost 600 of those people have been admitted to OMRDD's multiple disabilities units, meeting the multi-year commitment made to OMH in 1982. In October 1987, we formulated a new plan with OMH which, with Legislative support, will result in the transfer of an additional group of several hundred multiply disabled individuals.

In addition, OMRDD acknowledges the difficulties presented by developmentally disabled or multiply disabled people who are admitted to the acute psychiatric units of NYC municipal and voluntary hospitals. Resolving a dispute over the long term care needs of these people is generally not the primary obstacle to their placement. Availability of appropriate residential accommodations is.

OMRDD is seeking Executive and Legislative support to establish a small, new unit by March 31, 1988 which will enable us to transfer 12 individuals who are "blocking" beds in New York City hospitals. OMRDD successfully undertook a similar effort about eighteen months ago. While the number is small, according to your data, the discharge of these people will create a hospital capacity for 132 typical psychiatric patients.

Until supply matches demand, OMRDD will continue to work cooperatively with OMH to alleviate immediate needs. The transfer of the people in acute psychiatric facilities is one example of this effort. Also, on February 15, 1988, OMH and OMRDD signed a new agreement which provides the framework for local cooperation and dispute resolution. During FY 1988-89, OMRDD expects to serve a total of 700 "special populations" individuals, including those with a dual diagnosis of mental retardation and mental illness.

Consistent with the report recommendation, OMRDD supports OMH's efforts to join us in crisis intervention by providing psychiatric resources to OMRDD's crisis intervention teams and to OMRDD's community clients.

The report recommends codifying the dispute resolution mechanism between OMRDD and OMH (Recommendation 9). I suggest that the new cooperative agreement be given a chance before any codification of the dispute resolution mechanism is considered.

OMRDD appreciates CQC's recommendation and support for the development of crisis residences to provide immediate services to developmentally disabled people.

Again, thank you for the opportunity to comment on these preliminary findings and recommendations.

Sincerely,

Arthur Y. Webb
Commissioner

AYW/BAH

Attachment

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

DAVID AXELROD, M.D.
COMMISSIONER

March 2, 1988

Dear Mr. Sundram:

In response to your recent request, Department staff have reviewed the Commission's report to the Legislature on Admission and Discharge Practices of Psychiatric Hospitals. Overall, we found it to be a comprehensive and thoughtful document.

We share your concerns with respect to discharge planning activities for psychiatric patients from Article 28 hospitals, both for those who are being transferred after a period of hospitalization as well as for those patients determined not to require admission. We believe adequate regulations are in place to govern the discharge of psychiatric patients to facilities with appropriate and sufficient supportive services. However, the lack of appropriate supportive services for psychiatric patients in many areas of the state makes accomplishment of such arrangements very difficult. Hospitals attempting to comply with the regulations and to make the necessary discharge planning arrangements face an increasingly formidable task. Your efforts to highlight this situation are well directed.

In general, we support the recommendations of your report; however, we have some concerns about recommendations 2 and 12. Recommendation 2 suggests that occasional overbedding of acute psychiatric inpatient units is preferable to transfers of acutely ill patients to state psychiatric facilities that are ill equipped or staffed to respond to their needs. The Department has equal concerns about the staffing, equipment, or ability of the acute care units to meet this almost constant overflow of acutely ill psychiatric patients. We are working with the New York City Health and Hospitals Corporation to grant emergency temporary expansions of bed capacities in a number of psychiatric units even as we have encouraged the development and implementation of effective long range plans to meet this growing patient population. We would suggest this as a realistic alternative to holding patients in the emergency service, or in unauthorized overcensus conditions.

We agree with the clinical intent of recommendation 12, which suggests that the first visit of patients to the outpatient program to which they are being discharged, should occur prior to discharge. However, given the delays already noted in your report, we urge that such arrangements be carried out in a fashion that does not further slow the discharge process.

Please let me know if we can be of further assistance in this regard.

Sincerely,

David Axelrod, M.D.
Commissioner of Health

Hon. Clarence J. Sundram, Chairman
NYS Commission on the Quality of Care
for the Mentally Disabled
99 Washington Avenue
Suite 1002
Albany, New York 12210

The City of New York

SARA L. KELLERMANN, M.D.
COMMISSIONER

DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND ALCOHOLISM SERVICES
93 WORTH STREET
NEW YORK, N. Y. 10013
TEL. 566-4830

February 23, 1988

Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Sundram:

On behalf of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, I commend the Commission for its comprehensive and timely report, Admission and Discharge Practices of Psychiatric Hospitals, dated January, 1988.

As you know, the Department has for several years made recommendations consistent with those set forth in the report, and agrees that the process for change should begin immediately. As has been well documented, New York City is facing a system-wide crisis in the adult inpatient/emergency room service sector and State support is required to correct the major problems affecting the continuum of psychiatric care. Your report provides useful information regarding many of these problems. In particular, the Department would support action on the following recommendations:

1). Transfers of patients from acute inpatient services who require intermediate or long term care should be expedited. State psychiatric centers are better able to provided the appropriate level of care. Also, such tranfers would assist in efforts to relieve overcrowding in the acute inpatient and emergency room units.

2). Additional funding for program development for mentally ill chemical abusers, both on an inpatient and outpatient basis, should be encouraged.

3). The FY 1988-89 Executive budget recommendations for enhanced State community residential service development, including RCCAs, should be supported.

4). Consideration should be given to utilizing unused land or excess psychiatric center buildings as a resource to spur development of additional skilled nursing facilities to meet the needs of the large numbers of mentally ill persons who require that level of care.

5). The State Office of Mental Health should continue to evaluate the existing array of day services in light of the changing needs of the patients being served, and to identify and develop services which respond to those needs, including the recently announced intensive case management program; walk-in psychiatric clinics with extended hours; vocational education and work supported opportunities; psychosocial clubs; and patient-run self-help programs.

Finally, with regard to the need to expand acute care psychiatric beds, it should be noted that the newly established psychiatric inpatient reimbursement rates may provide disincentives for local service development, particularly with respect to the loss of fiscal incentives to support hospital-based outpatient programs. This could be especially serious in the face of the State's intention to continue to reduce their intermediate and long term care census, in spite of the increased need for intermediate care.

The Department is pleased to acknowledge the support of Commissioner Richard C. Surles in seeking to work collaboratively with the City in reviewing these matters.

In conclusion, I commend the Commission on its excellent work in preparing this report and I look forward to working with the Commission and the SOMH in implementing these recommendations.

Sincerely,

Sara

Sara L. Kellermann, M.D.
Commissioner

SLK/lc

cc: Martin S. Begun
Richard C. Surles, Ph.D.
Phillip McDowell, NYSCLMHD

The City of New York

MARTIN S. BEGUN
CHAIRMAN

THE COMMUNITY SERVICES BOARD
DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND ALCOHOLISM SERVICES
93 WORTH STREET
NEW YORK, N.Y. 10013
TEL. 212-431-3732

February 29, 1988

Clarence J. Sundram
Chairman
New York State Commission on Quality
of Care for the Mentally Disabled
99 Washington Avenue
Albany, New York 12210

Dear Mr. Sundram:

On behalf of the members of the Community Services Board of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, thank you for the opportunity to comment on the Commission's January, 1988 report on Admission and Discharge Practices of Psychiatric Hospitals. The Commission's findings and recommendations are comprehensive, and recognize the need for change in a system with ever growing populations of multi-disabled persons requiring a wide range of non-traditional services.

As you know, the New York City Community Services Board is authorized under both State and local law to serve as the primary advisory body to the New York City Department of Mental Health, Mental Retardation and Alcoholism Services. In this capacity, the Board has often lent its support to initiatives proposed by Commissioner Sara L. Kellermann, New York City Department of Mental Health, Mental Retardation and Alcoholism Services, for the restructuring and enhancement of the mental hygiene service system in order to provide the appropriate continuum of care services to the various populations in need of treatment and care.

In a letter dated February 23, 1988, Commissioner Kellermann indicated the Department's support of actions to implement

specific recommendations contained in the Commission's report. For the members of the Community Services Board, I am pleased to note for the record that the Board supports the comments contained therein.

We look forward to the implementation of the Commission's recommendations.

Sincerely,

Martin S. Begun
Chairman

MSB:dm
cc: Sara L. Kellermann, M.D.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

125 Worth Street ● New York, New York 10013

Jo Ivey Boufford, M.D.
President

Luis R. Marcos, M.D.
Vice President
Mental Hygiene Services

February 5, 1988

Honorable Clarence J. Sundram
Chairman
Commission on Quality of Care for
The Mentally Disabled
99 Washington Avenue - Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

Thank you for sharing with me the Commission's recent report on Admission and Discharge Practices of Psychiatric Hospitals.

Let me take this opportunity to commend the Commission for their well delineated presentation of the duress with which the mental health system, particularly in New York City, is currently operating. The report effectively identifies both the etiology of an oversubscribed inpatient treatment system as well as the obvious need to bring about the kinds of systemic changes that emphasize the establishment of appropriate and sufficient community based services. In particular, we want to underscore our support for those program recommendations that provide alternatives to hospitalization and create discharge resources following inpatient care--supervised and supportive community residential facilities, crisis residences, intensive day treatment, case management, family support programs, expanded outpatient programs with a capacity to provide educational and vocational services, family support programs and walk-in psychiatric clinics. In addition, we were pleased to note the recognition of the unique treatment needs of special population groups that include the dually diagnosed; the mentally ill chemical abuser; and the geropsychiatric patient with concommitant medical conditions that warrant placement in HRF or SNF levels of care. The New York City Health and Hospitals Corporation is in the process of bringing some of the above referenced programs into its mental health service system in order to reduce the utilization of inpatient services.

The Commission's report accurately identifies the need for the continued rapid development of community residential placement. The Corporation would like this recommendation to be expanded to include requirements that would ensure access to community residence placments for those patients that are not routinely accepted-i.e. persons with alcohol/drug problems, and the dually diagnosed. In

addition, the admission process itself needs to be streamlined in order to allow for discharge to a community residence to occur within the time parameters of an acute care length of stay.

Finally, while we share the Commission's desire to phase out the Tripwire Agreement in a timely fashion, we must underscore the fact that this should not take place until such time as the other Commission recommendations have been implemented and thus obviate the need for the Tripwire Agreement.

I trust that these comments will be useful to you and look forward to receiving copies of the final report.

Sincerely,

Luis R. Marcos, M.D.

cc: Jo Ivey Boufford, M.D.
Richard A. Sheola

ACLAIMH association of community living agencies in mental health
c/o NYSARF 155 Washington Ave., Albany, New York 12210 • (518) 449-2976

March 11, 1988

Mr. Clarence J. Sundram
Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

On behalf of the Association of Community Living Agencies in Mental Health (ACLAIMH), I want to thank you for the opportunity to review and comment on your report of Admission and Discharge Practices of Psychiatric Hospitals.

As you know, ACLAIMH represents voluntary agencies which provide community residence programs for the psychiatrically disabled. At this time, there are approximately 6,000 voluntary community residence beds certified by the New York State Office of Mental Health, and the current proposed Executive Budget supports further expansion of these programs.

The report of Admission and Discharge Practices delineates a number of findings with which we agree. We support the expansion of the number and type of community-based support services. In the area of residential services, we are recognizing the special needs of the multiply disabled population. Although we do serve individuals with mental illness and alcohol abuse, and mental illness and substance abuse, within our existing programs, we have identified the need for specialized residential models. Additionally, development of crisis residences may assist in providing an alternative for some individuals; specifically, some who are currently admitted for acute psychiatric inpatient care, and some individuals who could benefit from a more intensive setting when discharged from inpatient care in the community, prior to their return to home or a community residence.

In our opinion, the types of outpatient services also need to be expanded. For the community-based mental health system to function effectively, appropriate treatment and support services must exist in local communities. From our perspective also, the population needing residential services in the community has changed over the years. We therefore strongly support the development of

drug and alcohol treatment programs for the mentally ill chemical abuser, and diverse vocational, educational and work-supported opportunities. If our community-based mental health system is to offer rehabilitative services, a network of options is needed to address individual needs. Because there are major differences in dynamics in various parts of the state, mental health services which are needed may vary depending on the geographic area. It appears that new and innovative programs would best be developed based on needs identified in each locality, with flexibility and collaborative long-range planning being highly important.

ACLAIMH represents agencies which are committed to providing quality services to the psychiatrically disabled and to planning for the changing needs of the population needing services. If we can be of any assistance in these endeavors, please do not hesitate to contact me.

Sincerely,

Kathleen Roberts

Kathleen Roberts
President, ACLAIMH

cc: Senator Nicholas A. Spano

Lewis County Community Mental Health,
Developmental Disabilities and Alcoholism Services

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February 2, 1988

Clarence J. Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Ave., Suite 1002
Albany, N.Y. 12210

Dear Mr. Sundram,

I am writing in response to your kind offer to submit comments and reactions to the Commission's preliminary findings and recommendations regarding admission and discharge practices of psychiatric hospitals. I will address my comments to five major issues addressed by the report.

The Multiply Disabled. As you know, this is a critical issue for County directors, as we are responsible for all disability groups. It has often been our perception that the individual Offices/Divisions are unresponsive to the needs of persons suffering from more than one of the mental disabilities. To date the IOCC has been ineffective in addressing these issues. For example, the Conference of Local Mental Hygiene Directors has been unsuccessful so far in getting the IOCC to develop a policy stating which Office is responsible for the needs of developmentally disabled persons in need of acute psychiatric services. I would suggest that your recommendations address the need for a means of fixing accountability for the multiply disabled population, be it to strengthen the IOCC, or some other approach. Also, I would like to see your recommendations include encouraging local voluntary hospitals to develop specialized acute care units for this population, and psychiatric centers to develop similar longer-term units. Until this is done, the needs of this most severely disabled group can not and will not be met. To continue a public policy which ignores this group is unconscionable.

Role Confusion. This is clearly an important issue. Your report notes the significant percentages of clinic, continuing treatment, and day training and treatment programs operated by the State. What is not asked is:

How many of these day programs were established in accordance with local planning efforts as mandated by Article 41 of the Mental Hygiene Law? The answer is that few were. The major cause of role confusion is that the State agencies ignore State law regarding mental hygiene planning. I welcome the recommendation "to develop clearly understood, workable and complementary roles for the State, local and voluntary providers." To this end, you might recommend that the Commission sponsor a workgroup on planning, and that it include the Conference, voluntary providers, and the Office of Mental Health.

Bed Blockers. Your findings in this area are enlightening. I believe your recommendations would be strengthened if you suggested that OMH establish a discrete placement unit fixed with the responsibility of identifying such persons and placing them in more appropriate settings.

Outmoded Day Services. Again the report identifies a critical issue. The need to establish more flexible, client-centered services is frustrated by rigid and inappropriate regulations. For example, in rural areas regulations must be rendered more flexible in order that services can address the unique needs of small numbers of constantly changing and multiply disabled persons. In all areas, regulations make it difficult to develop appropriate day programming for the multiply disabled. I suggest that you recommend that OMH undertake a process of reviewing regulations for day services with the goal of rendering them more flexible and client-oriented.

Increased Emphasis on Case Management. I strongly endorse this recommendation. The expanded CSS program is the most significant step that New York State has taken in years to provide needed community services to those in need. Case management is expanding rapidly due to CSS.

Thank you for this opportunity to comment.

Sincerely,

Philip E. McDowell, M.S.W.
Director

PEM. djb