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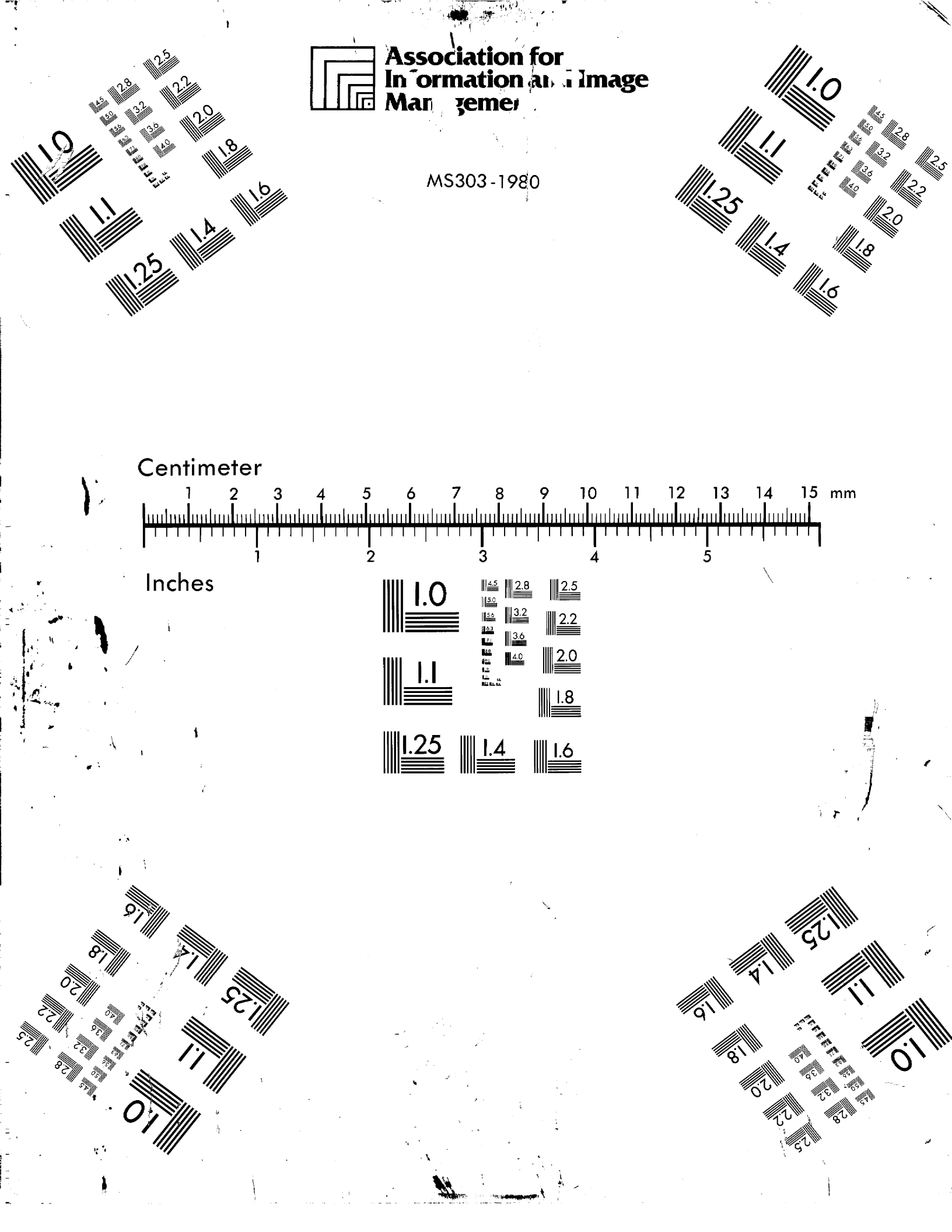
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NEW YORK STATE COMMISSION ON

# QUALITY OF CARE for the Mentally Disabled

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STATE OF NEW YORK

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## ANNUAL REPORT 1994-95

| QUANTITY | DESCRIPTION OF SERVICES--July 1, 1994 to June 30, 1995 | Amount |
|---|---|---|
| 47,992 | Persons Served Through PADD, CAP,& PAIMI Networks | |
| 11,860 | Complaints Acted Upon | |
| 5,565 | Reports of Suspected Adult Abuse Reviewed | |
| 2,312 | Recommendations Made | |
| 607 | Site Visits | |
| 285 | Deaths Investigated | |
| 344 | Surrogate Decision-Making Cases Reviewed | |
| 137 | Reports of Suspected Child Abuse Responded To | |
| 5 | Published Reports | |
| | TOTAL EXPENDITURES FOR SERVICES | |
| | State Operations | |
| | General Fund | $3,876,976 |
| | Special Revenue Fund - Federal | 3,009,808 |
| | Special Revenue Fund - Other | 964,980 |
| | Aid to Localities | |
| | General Fund | $ 34,664 |

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I certify that the above bill is just, true and correct, that no part thereof has been paid except as stated and that the balance is actually due and owing, and that taxes from which the State is exempt are excluded.

Clarence J. Sundram — Chairman

PAYEE'S SIGNATURE IN INK — Title

1994-95

Date

Commission on Quality of Care for the Mentally Disabled

Name of Company

| | |
|---|---|
| TOTAL | $7,886,428 |
| Discount % | |
| NET | $7,886,428 |

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# Foreword

Over the past few years, all levels of government have had to come to terms with the new reality that this is a period of retrenchment and downsizing the role of government, both nationally and in New York. The transition has required many demanding decisions and changes. The evidence of the challenge is all around us. Elected officials, who are increasingly being called upon to allocate scarcity, are finding it arduous to reach a consensus on priorities and on the means to live within reduced resources. Protracted budget disagreements and prolonged budget stalemates are a testament to the hard choices and difficulty of governing in this period of change and upheaval.

These are trying times not only for people with disabilities and their families who have relied upon government to provide a needed lifeline of support services but for those who have provided services and find their livelihoods imperiled by budget reductions. It is a period of changing expectations.

From the vantage point of a state oversight and advocacy agency, this is a good time to remind ourselves of the basic duties of the state in meeting the needs of its citizens with mental disabilities. Simply stated, these are to provide safety and quality care to those in its custody, and to maintain accountability over the vast network of service providers for both quality of service and expenditure of public funds. These core functions have always anchored the Commission's mission within state government. In the current environment of deregulation of process and downsizing of service providers and regulators, this type of outcome-focused oversight becomes all the more essential.

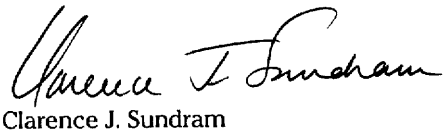
In this annual report, the Commission once again gives an account of its activities. The Commission's cost effectiveness studies have identified over $15 million in potential savings (report pp. 16-19), while its fiscal investigations and referrals to law enforcement agencies have resulted in a criminal conviction of the Administrator of the HI-LI Manor Home for the Aged (report p. 18), the revocation of the license to practice medicine of the former medical director of Brooklyn Psychosocial Rehabilitation Institute (report pp. 18-19), and a novel judicial ruling enabling the state to enforce a $7.5 million Medicaid fraud judgment (report p. 19).

Commission policy studies concluded a three phase study of restraint and seclusion practices in psychiatric facilities, the largest of its kind in the country (report p. 14), and commenced the first systemic examination of private psychiatric hospitals in the state (report p. 54).

Many of the Commission's policy and fiscal studies are spawned by its regular contact with the service system in the course of its day-to-day oversight activities, where potential systemic issues surface in dealing with individual cases. In the past year, Commission staff received and acted upon 11,869 complaints, reviewed 5,565 reports of suspected abuse or neglect, investigated 285 deaths, and made 2,312 recommendations for preventive, corrective or disciplinary action. In addition, the Surrogate Decision Making Committee program handled 344 cases involving consent to major medical treatment, saving providers the time and expense of seeking court orders, and freeing up judicial resources in the process.

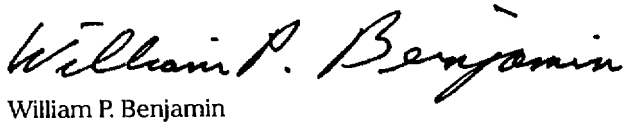
Finally, the Commission's federally funded network of advocacy services assisted 47,992 individuals in vindicating rights promised in state and federal laws.

The reality of scarcity requires of us a focused and disciplined effort to use public resources as efficiently and effectively as possible. We believe we have done so.



Clarence J. Sundram
CHAIRMAN

Elizabeth W. Stack
COMMISSIONER



William P. Benjamin
COMMISSIONER

# Contents

*The state has both the right and the obligation to securely confine patients who are believed to be seriously mentally ill and dangerous . . . At the same time, it has the obligation to ensure that patients who are not dangerous are also kept safe and are not needlessly deprived of their freedoms.*

# Ensuring Safety, Security, and Accountability in the Mental Hygiene System

The state has both the right and the obligation to securely confine patients who are believed to be seriously mentally ill and dangerous based on their recent past behavior, while they are treated in a psychiatric hospital. It has the right and the duty to ensure they do not escape and do not harm either themselves or others. At the same time, the state has the obligation to ensure that patients who are not dangerous are also kept safe and are not needlessly deprived of their freedoms.

Unfortunate incidents during the past year illustrated problems in maintaining this delicate balance. Two murders allegedly committed by patients of Kingsboro and Manhattan psychiatric centers focused Commission investigations on issues of safety, security, and general care and treatment at these two facilities. New legislation signed by Governor Pataki in the wake of these tragedies targeted the prevention of similar future occurrences by providing greater access to patients' criminal histories and records, which were issues in the two cases.

The struggle between choice and responsibility, empowerment and protection was illustrated in a Commission investigation into another tragic death: *In the Matter of Jacob Gordon.*

In the third in a series of reports on restraint and seclusion practices in New York State psychiatric facilities, the Commission examined the governance structure in current state law, regulation, and policy for the use of restraint and seclusion to determine if these provide adequate direction to ensure the safe and appropriate use of restraint and seclusion in New York psychiatric facilities.

# Safety and Security at Kingsboro and Manhattan Psychiatric Centers

The Commission reports, *Patient Safety and Services at Kingsboro Psychiatric Center*, July 1995, *and In the Matter of R.H.: A Patient of Manhattan Psychiatric Center*, April 1995, describe the tragic circumstances leading to the murders of two individuals by patients at the centers, one committed by a patient following his return to Kingsboro Psychiatric Center after he had escaped the prior evening, and the second committed by a patient after he escaped from Manhattan Psychiatric Center. The Commission began its investigations at the two centers pursuant to its responsibility to investigate unusual deaths and serious incidents of abuse or neglect at mental hygiene facilities. At Kingsboro Psychiatric Center, where the circumstances surrounding the incident raised more general questions about the safety, security, and quality of care provided to patients at the center, the Commission expanded its investigation to include a general review of patient care and treatment at this facility, as well as focusing on the center's investigation and response to untoward incidents.

## Kingsboro

On November 20, 1994, "George Allman" [a pseudonym] was stabbed to death in his bed at Kingsboro Psychiatric Center by "John Bishop" [pseudonym], another patient who was 49-years-old. Mr. Bishop had an extensive history of mental illness (first hospitalized for psychiatric treatment at age 7 and arrested on more than a dozen occasions for various criminal offenses, some involving violence, one for murder.) He also had a history of polysubstance abuse and homelessness. In 1984, Mr. Bishop was sent to Mid-Hudson Psychiatric Center as a result of a murder he allegedly committed of a fellow homeless shelter resident—Mr. Bishop said that the victim had been following him around and bothering him. He was adjudicated as not responsible for the act due to mental disease and placed in the Mid-Hudson secure forensic facility. On the two occasions that Mr. Bishop was transferred to Kingsboro Psychiatric Center, he threatened fellow patients, escaped, and then was promptly returned to Mid-Hudson. On September 29, 1994, he was sent to Kingsboro a third time, pursuant to a court order that he be transferred. Within two weeks of his arrival at Kingsboro, Mr. Bishop's psychotropic medications were cut in half with no written rationale, and there were no notes by Mr. Bishop's treating psychiatrist for most of the next two months. Mr. Bishop escaped from the facility the evening of November 19, 1994 and returned to the center the morning of November 20. Later that day, just after a physician had spotted a knife in one of Mr. Bishop's pockets while preparing the patient to be transferred to the secure care ward, the patient alerted staff to a dead body on the ward. Mr. Bishop was arrested in connection with Mr. Allman's death, a patient who may have been especially vulnerable to harm on this particular ward (Ward 22). Mr. Bishop was indicted for Mr. Allman's murder in the second degree.

The Commission's investigation determined that Mr. Bishop's escape from Kingsboro Psychiatric Center on November 19, his return the next morning, and Mr. Allman's death on November 20, reflected lapses in security and search practices, communications, and clinical judgment.

## Findings:

- Mr. Bishop escaped from a locked ward in a locked building. A patient was used to supervise other patients in transit to dinner, and staff failed to re-lock doors which were to be kept locked. Mr. Bishop's escape route took him past one security guard posted at a gate who failed to notice the patient's elopement.
- Off-duty senior facility administrators, including the Executive Director, were not promptly notified of the patient's escape and the events which later transpired. Additionally, the administrator on call did not provide assistance and guidance to the less senior staff on duty at the facility.
- Following Mr. Bishop's return to the center on the morning of November 20, he was not properly searched (body check was not performed) due to ambiguous search policies which left staff unsure as to what to do. Mr. Bishop allegedly used a knife hidden on his person which he had obtained while off the grounds to fatally stab Mr. Allman.
- Especially because the patient had been drinking while he was away from the facility, nursing staff advocated that Mr. Bishop be admitted to the secure care ward where patients would be more closely supervised. However, the treating psychiatrist returned Mr. Bishop to Ward 22, the ward he had been residing on, without orders specifying increased supervision for the patient.
- When the Executive Director was finally informed at 10:30 a.m. on the morning of November 20 of Mr. Bishop's escape from the center and subsequent return (17 hours after the incident), she ordered that the patient be transferred to the secure care ward. While

preparing Mr. Bishop for the transfer, the physician carrying out the Executive Director's orders saw a knife in one of Mr. Bishop's pockets. It was at this time that the patient informed the doctor that there was a dead body in the dormitory.

Mr. Allman was found with multiple stab wounds to his chest, and later died at Kings County Hospital due to perforations of the heart and one lung. None of the four staff nor the thirty-four patients on Ward 22 that morning recalled hearing or seeing anything unusual.

## Broader Investigation Into Conditions at Kingsboro

These circumstances which led to Mr. Bishop's escape and Mr. Allman's death were not isolated events, but were ongoing lapses in safety, security, incident follow-up and review, and in the quality of care provided to patients at Kingsboro Psychiatric Center.

- ***Safety And Security***

During the six weeks before and after the escape and homicide at the facility, there were 209 untoward incidents, almost a third (32%) of which involved patient-to-patient assaults or fights. This was the largest single category of reported incidents.

During the same six weeks preceding and after Mr. Bishop's escape and Mr. Allman's murder, there were fifty-six (27%) incidents which reported patient elopements. Most of these (94%) involved patients who had left locked wards, and thirty percent were patient escapes (patients who were assessed to be dangerous to themselves or others). In twenty-five percent of the cases, patients simply walked out doors which were supposed to be kept locked, frequently while being escorted to meals, as was Mr. Bishop. The facility's records reviewed indicated that senior administrators were very aware of this problem, along with staff's keys being lost and in patients' possession and the fact that one "master" key unlocks most of the buildings and wards at the facility. Unfortunately, they took no action until after Mr. Allman was murdered.

- ***Incident Follow-Up And Review***

The most immediate explanation underlying the murder of Mr. Allman concerns the mistakes, poor judg-

*New York Times,* January 19, 1995:

## *Pataki Plans Tighter Security at State Psychiatric Hospitals*

By DENNIS HEVESI

After a spate of escapes, including one by a mentally ill man who was accused of pushing a woman in front of a subway train two weeks ago, Gov. George E. Pataki announced a plan yesterday to tighten security at psychiatric hospitals throughout the state.

The plan calls for identification tags to be worn by everyone on the grounds of the state's 29 mental hospitals; assignment of staff members to locate missing patients, and a review of how patients are granted privileges to go into the community.

"This plan will without question make these hospitals more secure for patients and for residents who live near the facilities," Governor Pataki said. "We will aggressively monitor these improvements and take further steps as warranted."

Officials said they had not drawn up cost estimates for the new measures, but there was no indication that the steps outlined would involve hiring additional workers. "It's not going to be a significant fiscal hit," said a spokesman for the Governor, Robert J. Bellafiore.

Clarence J. Sundram, chairman of the state's Commission on Quality of Care, which monitors the mental health system, said the plan contained "much-needed measures to improve accountability for both patient safety and public safety."

But D. J. Jaffe, a board member of Friends and Advocates for the Mentally Ill, said the answer to keeping patients from escaping or failing to return from leaves is not to make the hospitals more like prisons, but to improve care.

The security plan was impelled by the case of Reuben Harris, a mentally ill man accused of pushing a 63-year-old retired seamstress, Soon Sin, to her death under a subway train on Jan. 4. Mr. Harris had been classified as violent and dangerous by state psychiatrists less than a year ago and was committed to the Manhattan State Psychiatric Center on Wards Island. But once he was there, state doctors repeatedly gave him the freedom to walk the large campus despite four escapes, mental health officials said.

In the wake of the Harris case, Mr. Pataki dismissed Bruce E. Feig, the Acting Commissioner of the Office of Mental Health. Mr. Pataki chose William F. Morris, a senior deputy commissioner for operations, to temporarily replace Dr. Feig.

In November, a series of escapes from the Kingsboro Psychiatric Center in Brooklyn, including one by a patient who returned the next day and, according to the police, stabbed a man to death with a knife he had smuggled onto the ward, raised questions about security at the five state psychiatric centers in New York City.

***A series of escapes and a subway killing raise questions.***

Over the previous 12 months, about 25 percent of the more than 12,000 patients treated at the five hospitals left the grounds without permission. Of those, 303 were patients who had been committed by the courts or who were considered dangerous to themselves or others.

The new security plan requires these, among other measures:

¶ Everyone on hospital grounds must wear identification tags. Currently, staff members wear such tags, but patients and visitors do not.

¶ All ward and building locking systems should be reviewed, and improved where needed.

¶ Existing outpatient staff should be reassigned to locate missing patients who are considered at high risk of danger to themselves or others. Now, the police are supposed to be informed if such a patient is missing, but critics have contended that the hospitals make little effort to find the patients.

¶ Appropriate staff and family members should be immediately notified, as well as the police, when a patient is missing.

¶ Each hospital should have a calling system to insure that a patient who has left the grounds has arrived at the proper destination.

"We also are moving to get information for our doctors and other clinicians to help them make the best possible decisions on whether someone should be granted privileges to walk unescorted from one place on hospital grounds to another," Mr. Morris said yesterday. He said that the plan would take effect first in New York City psychiatric centers, then statewide.

Mr. Jaffe, however, said the Governor's announcement "is designed to satisfy the public, not solve the problem."

He said his advocacy group felt three things were needed: "Improve care so fewer people want to leave; create community-based housing for those who are ready to leave, and, for that small percentage who are dangerous—most likely to themselves—they should be required to take their medication as a condition for living in the community."

Mr. Sundram of the Quality of Care Commission said that the primary challenge would be to identify those patients who pose a danger. The Governor's plan, he said, "is a recognition that common sense and compassion can coexist."

ments, and misconduct of staff at the center. Virtually all these staff performance problems were well-known to senior staff at the center, and had surfaced on most of the adult wards at the hospital during the past year. Interestingly, although topics for discussion at management and committee meetings, these issues were not effectively addressed in a timely manner either by Kingsboro's own internal quality assurance mechanisms and management team nor by the Office of Mental Health New York City regional and central offices, both of which were routinely notified of many of the serious incidents occurring at Kingsboro Psychiatric Center.

- ***Quality Of Care***

  Kingsboro Psychiatric Center is providing treatment for a substantial number of patients requiring acute psychiatric care, individuals often with severe psychiatric illnesses and polysubstance abuse. Not only are many of these patients dangerous, they are also resistant to treatment, treatment which is inadequate for patients with alcohol and drug abuse problems at the facility. Further, the center's limited physical space leading to overcrowding has resulted in the placement of violent and dangerous patients on wards with vulnerable patients.

## Manhattan

On January 4, 1995, ten days after his elopement from Manhattan Psychiatric Center, R.H., a 42-year-old patient with a 20-year history of drug abuse and serious mental illness resulting in multiple arrests, numerous psychiatric hospitalizations, and homelessness, allegedly pushed a woman into the path of an oncoming New York City subway train which killed her. Over the past twenty years, R.H. was hospitalized for mental illness on at least fifteen different occasions, and diagnosed as schizophrenic with cocaine and alcohol abuse. R.H. was also arrested a dozen times on charges ranging from misdemeanor infractions to felonies. In 1983, he was charged with striking a woman on the street causing a concussion, in 1984, with assaulting a woman in the subway on her head with an umbrella, and in 1988, with slashing the face of a male passenger on a subway train with a straight razor when he did not give R.H. the change for which he had asked. Although R.H. spent time in correctional facilities for some of these crimes and received mental health services while incarcerated, most often he was committed to psychiatric facilities rather than being prosecuted. Typically, R.H. eloped during his hospitalizations, and when he returned, drug testing results were often positive. He sometimes returned voluntarily, but other times was discharged for failing to return within several days, and was found not to be a danger to himself or others in clinical records. Miscalculations about R.H.'s dangerousness had been occurring for nearly twenty years. This habitual pattern was displayed multiple times, including the year prior to the incident on January 4, 1995 when R.H. allegedly pushed a woman to her death in the subway. In late November 1994, R.H. was granted unescorted grounds privileges and then eloped one month later from the facility on Christmas Eve. R.H. was arrested and charged with second degree murder on January 4, 1995, and sent to the forensic ward at Bellevue Hospital Center for evaluation.

## Investigation Findings

The Commission's investigation at the center revealed that R.H.'s elopement from Manhattan Psychiatric Center on December 24, 1994, and the death of the 63-year-old grandmother who R.H. allegedly pushed into the path of an approaching subway train reflected lapses in access to information about patients' histories, the process governing the granting of unescorted grounds rights to patients, the classification of elopements as leaves-without-consent (LWOC's) or escapes, and the lack of effective action and involvement on the part of R.H.'s Intensive Case Manager (ICM) in his treatment.

- ***Access To Information***

  During R.H.'s most recent hospitalization at the center, sufficient information was available to staff for them to know of his history of previous hospitalizations, incarcerations, substance abuse, leaves without consent, and violent assaults. However, they did not review all the information regarding R.H.'s previous admissions at the center or at other facilities. Further, R.H.'s "rap sheet," documents not available for non-CPL [Criminal Procedure Law] patients, would have alerted staff to the outstanding bench warrant (since April 1993) for his arrest for criminal possession of a weapon, menacing, and disorderly conduct. It is unclear, however, if staff at the center would have been able to alert police to the patient's whereabouts or unwilling to communicate information they believed would violate his confidentiality.

- ***Granting of Grounds Rights***

  Even though R.H. had four leaves without consent in 1994 prior to his last elopement on Christmas Eve of that same year, he was granted grounds rights several

times. The last pass was approved on November 23, 1994, while he was a patient on the MICA Unit. During 1994, twenty-eight percent of all LWOC's and thirty-seven percent of all escapes from the center involved patients on the MICA Unit. Apparently, there is pressure to grant grounds rights to patients to facilitate their eventual discharges. Attending rehabilitation programming, which is held in a separate building on the grounds, is contingent on patients first being granted unescorted grounds rights due to a lack of enough staff available to accompany patients to programming. Additionally, in order to be placed in a supervised residence, patients must have a track record of unescorted grounds rights without incident for two to three months.

- ***Classification of Elopements***

  The classification of incidents of patient elopements as LWOC's (for non-dangerous patients) or escapes (for patients assessed to be a danger to themselves or others) apparently is based only on the patient's *recent* behavior *in the hospital*, rather than his *potential for violence*, as demonstrated by *past* behavior *out of the hospital*.

- ***ICM Notification and Actions Taken***

  Although R.H.'s Intensive Case Manager (ICM) was listed as his significant contact in the treatment record, facility staff did not notify the ICM after any of R.H.'s four elopements, including the last one on December 24, 1994. Additionally, the ICM was not aware of R.H.'s propensity toward violence and his past criminal activity, despite having received the patient's core history which addressed these issues from his most recent admission to the center. And lastly, the ICM treatment plan did not address R.H.'s frequent elopements, despite this being a significant barrier for discharge to a supervised setting.

## Commission Recommendations from the Two Investigations

The Commission has suggested a number of recommendations to address the concerns identified in these two reports.

- The state's psychiatric centers' provision of inpatient services needs to be targeted toward intermediate and long-term care and away from the acute care patient roles they currently occupy. The overcrowding at Kingsboro Psychiatric Center must be reduced by eliminating direct admissions, diverting admissions to other hospitals, and establishing census caps of 25-30 patients per ward.
- Patients with violent histories should be placed on special wards with enriched numbers of staff specially trained to intervene with their violent behavior.
- Clinical and direct care staff need to receive specialized training in meeting the treatment needs of patients with concomitant drug and alcohol abuse problems—a population that currently comprises fifty percent of the admissions to psychiatric centers in New York City.
- OMH should re-examine its policies and practices regarding the care and treatment of all patients with past histories of violent behavior toward themselves or others and substance abuse. Facilities need to have reliable and accurate information of patients' past behaviors and hospitalizations, regardless of their legal status, to develop effective treatment plans and to make decisions regarding the conditions under which they can be granted liberty without risking harm to themselves or others. At a minimum, records from all secure hospitalizations and for all CPL admissions should be obtained. OMH should consider the value of using the conditional discharge provisions of MHL§29.15 to provide options for the supervision and protective monitoring of such patients in the community.
- OMH should consider expanding the scope of the DMHIS, a computerized information system to include non-state-operated facility hospitalizations. These hospitalizations account for most of the admissions in the mental health system. Additionally, the DMHIS should note whether a patient was discharged from LWOC or escape status.
- Patients who have eloped from the facility should not be automatically discharged after the passage of a specified amount of time, as is current policy and practice. There should be a clinical review in each individual case to determine what follow-up actions are appropriate to ensure the safety of the patient and the community.
- The significance of a patient being an outpatient of the Central New York Psychiatric Center (a forensic hospital) needs to be more widely disseminated in the mental health system. This would alert staff to patients' criminal histories and possible violent behavior.
- Coordinators of the ICM program need to ensure that ICM's are effectively included as members of patients' treatment teams, and that they are advised of all significant events, including the granting of grounds privileges to patients and elopements.

*"The people of New York deserve better protection from escaped mental health patients with a violent past. Recent events confirm the need for this legislation as well as other measures that will ensure the safety and security of our citizens. This legislation will help protect New Yorkers from the small minority of people with mental illnesses who are dangerous."* — *Governor Pataki*

- Through increased supervision, a decrease in overcrowding, and better staff compliance with new policies and procedures, incidents which endanger patient and staff safety must be reduced. The substantive problems with incident reporting, investigation and lack of effective follow-up of corrective actions must be resolved, and the occurrence of untoward incidents reduced.
- OMH should develop an effective system for monitoring the operations and quality of care provided by the five state psychiatric centers in New York City.

The Commission will continue to monitor conditions at Kingsboro and Manhattan Psychiatric Centers and the implementation of recommendations and the necessary corrective actions delineated in these reports.

## Task Force Addresses Security and Discharge Issues

Following the tragedies at Kingsboro and Manhattan psychiatric centers, the Office of Mental Health and the Commission, recognizing that long range reforms related to the treatment, discharge, and follow-up of patients with histories of violence are necessary, established a joint task force to address treatment, discharge, and follow-up issues.

The task force was comprised of representatives of the Office of Mental Health, Commission on Quality of Care, consumers of services and families, and representatives of the New York City Department of Mental Health. The group was charged with:

1. Examining current treatment and discharge planning procedures, especially for a cohort of individuals who have histories of serious mental illness, concomitant drug abuse, and repeated aggressive or criminal behavior;
2. Making recommendations to the Office of Mental Health and the Commission on Quality of Care for ways to improve treatment planning and discharge planning procedures, and in particular, ways to increase meaningful patient participation in these processes, and
3. Making recommendations for follow-up steps that could assist in implementation of these recommendations.

The task force convened and expeditiously produced a thoughtful set of recommendations [see joint public statement next page].

## Governor Signs Security Legislation

On July 21, Governor Pataki signed legislation which will give institutions and programs operated by the Office of Mental Health complete access to their patients' criminal records. In both the Kingsboro and Manhattan tragedies staff were not aware of the patients' violent histories, the patients escaped because of breakdowns and failures in security, and serious efforts were not made to locate the individuals once they escaped.

This legislation recognizes that it is extremely important for facilities and programs to obtain reliable information on patients' past behavior for use in treatment planning and to make patient privilege decisions to safeguard both patients and the community. While institutionalized, patients with histories of criminal or violent behavior often respond to medication and structured treatment. If they escape or are released inappropriately, they may stop taking their medication and fail to keep outpatient therapy appointments, often decompensating and using illegal street drugs which affect their personalities and, with the untreated underlying psychosis, can make them dangerous to themselves or others.

The new law states that the availability of this information "shall be used for purposes of making decisions regarding care and treatment, health and safety, privileges and discharge planning for patients admitted to or retained in hospitals operated by the Office of Mental Health."

In conjunction with the signing, Governor Pataki included in his statement:

> "The people of New York deserve better protection from escaped mental health patients with a violent past. Recent events confirm the need for this legislation as well as other measures that will ensure the safety and security of our citizens. This legislation will help protect New Yorkers from the small minority of people with mental illnesses who are dangerous."

## Joint Statement of Joel Dvoskin, Acting Commissioner, NYS Office of Mental Health, and Clarence J. Sundram, Chairman, NYS Commission on Quality of Care

In the wake of recent tragic events involving patients who escaped from state psychiatric centers, the NYS Office of Mental Health and NYS Commission on Quality of Care established a Joint Task Force to address treatment and discharge related issues, especially as they affect a subset of patients served by the mental health system who both pose and experience special problems in recovery and community living.

On August 11, the Task Force submitted its report and recommendations. These recommendations address the following major areas.

1. To improve inpatient psychiatric treatment by:
   - engaging patients in rehabilitation activities earlier in the treatment process;
   - providing patient education programs in changing substance abuse behavior, managing anger, dealing with stress and understanding the consequences of violent behavior;
   - improving staff training and skills by developing in each psychiatric center expertise in the treatment of mentally ill chemical abusers;
   - providing training for professional staff in assessing a patient's likelihood of engaging in violent behavior, and in targeted interventions to reduce violence; and
   - supporting and training direct care staff in working with patients with significant behavior problems.
2. To improve treatment outcomes by urging staff to seek out and involve a caring family member, friend or peer advocate/counselor in the life of the patient, to work diligently with this person to enable the patient to return to life in the community.
3. To enhance patient safety by carefully screening and assessing all inpatients upon admission, to identify patients who by their histories of serious violent criminal behavior and current clinical status may require a higher level of security and/or behavioral programming, and to assure their safety and the safety of other patients and staff by separate residential and/or program areas as necessary.
4. To improve discharge planning and the follow-up of patients after discharge into the community, especially for the subset of patients with histories of serious violent behavior, nonparticipation in outpatient treatment, and repeated rehospitalization, often after episodes of violent behavior. The Task Force recommends follow-up by an intensive case manager or assertive community treatment team to ensure implementation of all discharge plans for these patients, and, while there was not unanimity, there was considerable support among the members of the Task Force for the use of the conditional release law for these patients (MHL §29.15).

In a short period of time, the Task Force has deliberated and produced a thoughtful set of recommendations which are both sensible and reasonable, and has performed a valuable public service.

Some of the treatment and staff training recommendations made by the Task Force are already being implemented by the Office of Mental Health under the leadership of Dr. John Oldham, Chief Medical Officer. Dr. Oldham will review the remaining recommendations in these areas and prepare an implementation plan.

We have carefully reviewed recommendations in #3 and #4 (above). The Task force has obviously tried to balance the general policy of care in the least restrictive environment with the obligation the state bears to protect those in its custody from unreasonable risk of harm. We believe that the Task Force's narrowly tailored interventions for a small subset of patients, with identified and verifiable histories of repeated serious violent conduct, have found the right balance. They reduce the risk of reliance on stereotypes in decision-making and, by limiting restrictions to a narrow class, they help preserve liberties for the vast majority of patients served by the mental health system.

The time-limited use of the conditional release statute may permit inpatient facilities to discharge patients during their period of commitment under an appropriate set of individually tailored conditions to facilitate their safe return to community living, with appropriate supports to enhance their successful reintegration.

# In the Matter of Jacob Gordon: Facing the Challenge of Supporting Individuals With Serious Mental Illness in the Community

*A generation ago, a man like Jacob Gordon would have spent his years confined to a state institution. Deinstitutionalization efforts and community–based mental health service developments over the past several decades offered Mr. Gordon an alternative, but also fragmented the responsibility for meeting his multiple needs.*

Slightly over one year after the Commission's symposium on "Choice and Responsibility," the struggle between empowerment and protection, choice and responsibility is still clearly in the forefront as illustrated in the Commission's report *In the Matter of Jacob Gordon*. This was a case of a young man who had dreams, aspirations, and strong opinions about his mental illness and subsequent treatment, and who died tragically while his family and a multiplicity of care providers struggled to reconcile Jacob's wishes and actions with their own responsibilities for recommending treatment and insuring that he received the appropriate care.

"Jacob Gordon" [a pseudonym] died at the age of 35 from Neuroleptic Malignant Syndrome, a rare and sometimes fatal reaction to psychotropic medication. His emotional difficulties began during high school; he was subsequently diagnosed as having schizoaffective disorder. During most of his adult life, Mr. Gordon struggled with persistent symptoms of his illness—delusions, obsessive compulsive behaviors, social isolation, and inattention to basic self-care needs. Over the years, the exacerbation of delusional thinking and/or suicide attempts or gestures resulted in hospitalizations with lengths of stay lasting a few weeks to three or more months.

Throughout his lifetime, a variety of antipsychotic medication regimes were tried, however, most of them caused adverse reactions and were discontinued. A fairly new drug, Clozaril, was tried and had extraordinarily good effects on Mr. Gordon, but Mr. Gordon demanded that the dosage levels be lowered, and his symptoms returned. Mr. Gordon's aversion to taking medication was one of several areas with which he, his family, and the involved care providers struggled.

Like many other individuals with serious mental illness, Mr. Gordon was put off by things which tended to identify or label him as being mentally ill; he disliked taking medication, having to attend programs geared exclusively to mentally ill people, living with other mentally disabled adults, and keeping appointments with psychiatrists, therapists, and case managers. He, like anyone else, did not see himself in terms of his mental illness.

He was artistically and intellectually gifted, and had plans for his future: to attend college, associate with, as he put it, healthy people, nurture his artistic talents, and live on his own. A generation ago, an individual like Mr. Gordon would not have been given the choices he was afforded; he would have been institutionalized with little concern for his own issues of privacy, liberties, goals, dreams, and need for self-sufficiency. All his basic needs—food, shelter, clothing, medical and mental health care, and supervision—would have been provided under one roof—the institution.

Mr. Gordon was provided with the alternative to institutionalization—community-based services and housing. However, the responsibility for meeting Mr. Gordon's multiple needs was fragmented, and although some of Mr. Gordon's dreams were fulfilled, other basic needs were unattended.

With the support of family and a network of professional caretakers who provided him with supportive housing, intensive case management, medication therapy and monitoring, and rehabilitation opportunities, Mr. Gordon was able to secure a degree in literature and pursue his artistic endeavors. Unfortunately, Mr. Gordon also lived in filth and neglected his basic hygiene needs. Health problems were ignored as were other treatment issues. There were many times he did not receive his medications as prescribed, and when he went into a medication-related crisis he did not receive timely emergency care and subsequently died.

Mr. Gordon's choice to live his life as he wanted, which meant ignoring his mental illness and failing to consistently follow appropriate care and treatment recommendations (i.e., medication compliance and medical care treatment), was part of the problem which resulted in his death. However, the fragmentation of services provided to Mr. Gordon played an even greater role in his tragic end; not one specific provider involved in Mr. Gordon's life was aware of all his needs (mental, social, emotional and medical), nor was any one provider responsible for meeting these needs.

Mr. Gordon's extensive medication noncompliance was known to be a problem by his residential staff, however, his psychiatrist believed this problem to be minimal. Mr. Gordon had not attended his day program in weeks or months,

while his intensive case manager believed he was regularly attending. And when his landlord found Mr. Gordon in crisis the day before his death, he didn't know how to contact Mr. Gordon's primary service providers.

Mr. Gordon's case is an example of the challenge of honoring individuals' choices and decisions while ensuring that these individuals still receive the care and treatment they require; the risk of failure escalates as the degree of disagreement and the number of service providers involved in a person's life increases.

The risk presented in Mr. Gordon's case is one of which all service providers should be conscious. As such, the Commission recommended that the Office of Mental Health disseminate the report to all mental health service agencies as an in-service training tool and a vehicle to promote agencies' reflection and discussion about the adequacy of their existing policies and practices, and remedial action where needed.

In the report, the Commission offered recommendations on how facilities could revise and revamp their policies and practices to better manage and reduce the risk of failure through enhanced service planning and interagency coordination. The suggested questions and recommendations are listed below. The Office of Mental Health concurred with the Commission's recommendations and agreed to disseminate the report to all state-operated or licensed programs to serve as a teaching tool.

## Gordon Report Recommendations

- Where multiple agencies forge a treatment relationship with an individual who tends to be noncompliant with their recommendations, are there mechanisms in place to ensure that:
  - All the providers have an understanding of each other's specific role in service delivery?
  - All the agencies are aware of the potential areas of noncompliance (e.g., self-care, medication management, health care, program attendance, etc.), and the relative risks of harm associated with each?
  - All providers agree on strategies of care, particularly around issues pertaining to noncompliance, and methods for monitoring the plan of care and compliance issues?
  - One agency is designated as the lead agency responsible for monitoring all aspects of the plan of care?
  - The agencies periodically meet to collectively review the individual's progress and the need to revise service plans and that such meetings occur not when the calendar dictates, but as the individual's needs dictate?
  - Where individuals receive services from a private psychiatrist or therapist who may be unable to attend periodic meetings, the lead agency keeps the psychiatrist/therapist fully informed on all aspects of the individual's care?
  - The agencies and significant others (e.g., landlords, families, consumers, etc.) have means of contacting each other when emergencies arise?
- Where medication compliance is an issue to the point of individuals requiring supervision at medication times, do agencies' policies ensure that:
  - The level of supervision is sufficient to assure the individual actually ingests his or her medications?
  - Blood levels are periodically drawn to monitor medication compliance?
  - Staff are sufficiently aware of both the psychiatric and medical hazards associated with noncompliance?
  - Prescribing physicians are consulted about instances of medication noncompliance?
  - Alternative forms of effective treatment consistent with the patient's wishes have been adequately considered?
- When individuals develop signs or symptoms of illness which may be attributed to either a physical or psychiatric condition, does the agency act to ensure both a medical and psychiatric assessment?
- When the nature and extent of family involvement becomes an issue in care, do the agencies collectively address and resolve this with the same care and diligence they bring to bear on self-care, medication, health care, and other treatment issues?
- The Commission also believes there is a therapeutic benefit in case managers providing individuals hands-on assistance and serving as role models, furthering their service compact with clients, and assuring that service recipients are afforded a safe, clean environment.

# Governance of Restraint & Seclusion Practices by NYS Law, Regulation, and Policy

In September 1995, the Commission published the third in a series of three reports on restraint and seclusion practices in NYS psychiatric facilities. The first report focused on the rates of restraint and seclusion used across psychiatric facilities, while the second report focused on consumers' perspectives on the use of these interventions. The third report examined the governance structure provided in current state law, regulation, and NYS Office of Mental Health policy for the use of restraint and seclusion to determine whether they provide adequate direction to ensure the safe and appropriate use of restraint and seclusion in New York psychiatric facilities.

The Commission concluded in its report that New York's governance structure for restraint and seclusion offers both contradictory and incomplete guidance to psychiatric facilities regarding the use of these very restrictive and potentially hazardous interventions.

- NYS law does not address the use of seclusion in psychiatric facilities.
- Current NYS law governing restraint and New York's Code of Rules and Regulations governing both restraint and seclusion have not been updated in nearly twenty years, and certain provisions in state regulations conflict with this in state law and vice versa.
- State Office of Mental Health policy governing restraint and seclusion, the most comprehensive governance structure available, extends only to state psychiatric centers and does not apply to state-licensed psychiatric facilities, which today serve three of every four individuals hospitalized for psychiatric care in New York.
- Although there are well-recognized problems in the overuse of restraint and seclusion among the elderly, children, and persons with mental retardation in New York, special protections or safeguards are not offered to these vulnerable populations in either New York State law or regulations.
- In the absence of more comprehensive state law and regulation governing restraint and seclusion, individual psychiatric facilities have developed their own restraint and seclusion policies, but these policies do not uniformly incorporate the limited safeguards which are now present in state law and regulations.

The gaps and contradictory standards in New York's current governance structure for restraint and seclusion, together with the findings of other Commission investigations of inappropriate restraint and seclusion usage, led the Commission to recommend that the Legislature consider codifying a single comprehensive statute governing the use of restraint and seclusion in psychiatric facilities to replace four sets of inconsistent directives contained in state law, regulations, OMH policies, and JCAHO standards.

In this endeavor, the Commission offered a number of principles which reflected the best practices of some facilities in New York State and provisions drawn from existing laws, regulations, accreditation standards and policies. Based on these principles, the Commission advocated that statutory reform should establish a cohesive governance structure over the use of restraint and seclusion which:

- provides uniform protection for patients related to restraint and seclusion use in *all* inpatient psychiatric facilities;
- provides comprehensive safeguards governing the use of *both* restraint and seclusion;
- assures that critical expectations for patient safety, well-being and protection from harm while being restrained or secluded are clarified and consistently monitored;
- assures special protections in restraint and seclusion use with vulnerable populations including the elderly, children, persons who are mentally retarded, and persons with serious medical conditions;
- requires sufficient documentation of the practices followed and their justification to provide an accurate and accountable record of a facility's restraint and seclusion practices; and
- builds in comprehensive quality assurance oversight by inpatient psychiatric facilities themselves and the NYS Office of Mental Health of restraint and seclusion practices.

The Commission recommended that these principles guide the Legislature in universally ensuring that the use of restraint and seclusion in psychiatric facilities is an option of last resort, carefully carried out and vigorously monitored. While the Legislature considers statutory reforms governing the use of restraint and seclusion, the Commission also recommended that psychiatric facilities review the principles set forth and determine the degree to which these principles are embodied in their existing policies and practices, and, where necessary, the need to enhance such policies and practices to better protect the people they serve.

*In the conduct of studies, instances are found where the taxpayer who pays for these services has been cheated and taken advantage of along with the mentally disabled consumers. . . .*

# Toward Affordable Human Services: Keeping the System Efficient and Honest

Bearing in mind the new era of less government spending and lower taxes, the Commission has been cognizant of its responsibility to assure that scarce state dollars are only spent in providing care to those most in need and not wasted. During 1994-95, the Commission has undertaken major systemic studies to examine ways to promote efficiency in the utilization of existing resources. When, in the conduct of studies, instances are found where the taxpayer who pays for these services has been cheated and taken advantage of along with the mentally disabled consumers who were the intended recipients of tax monies by operators who defraud the system, the Commission has made referrals to state and federal law enforcement agencies, which have resulted in civil and criminal investigations, successful prosecutions, and professional disciplinary actions.

# Preventing Waste and Inefficiency . . .

*The elimination of duplicate reimbursement of costs and reductions in rates for administrative expenses are expected to save the state $3 million annually.*

## OMRDD Rate Appeals: Flawed Payment System

A Commission examination of the OMRDD system for processing appeals of Medicaid rates for intermediate care facilities (ICFs) and community residences (CRs) began after it was found that a programmatically deficient agency (*Missing Accountability: The Case of Community Living Alternative, Inc.*, June 1994) received a retroactive payment of $138,798 to fund additional direct care staff that were never hired because OMRDD did not examine agency expenditures to determine whether the costs had been incurred. These funds were subsequently misappropriated by an executive director who had been diverting over 25 percent of the agency funds into his own accounts through checks written to "cash."

The Commission's January 1995 report, *Safeguarding Public Funds: A Review of Spending Practices in OMRDD Rate Appeals,* describes how the system which is intended to ensure that Medicaid rates are sufficient to cover the costs of efficiently-run facilities, granted appeal funding of $22 million in 1991, even though in many cases the money either was not spent on the purpose for which it was claimed, or not spent at all. OMRDD failed to use the system to prevent the funding of excessive administrative costs, restrict spending to the purpose of the appeals, or to recoup appeal monies that were not spent. It granted appeal funds to rescue agencies with long histories of fiscal mismanagement and substandard care without prior audits to determine the reasons for why additional funds were needed and without assurance the defective practices had been corrected. Providers also received duplicate funding for property costs, high occupancy levels and for variable costs not incurred when beds were vacant.

Since the Commission released its study findings to OMRDD, modifications have been made in the rate appeals system and written procedures adopted. The elimination of duplicate reimbursement of costs and reductions in rates for administrative expenses are expected to save the state $3 million annually.

## Millions Wasted through Misguided Medicaid Initiative

A study completed in 1995 found that OMRDD's implementation of a program for consumers residing in the community which was intended to save money by shifting costs to Medicaid has resulted instead in millions of dollars of unnecessary costs through improper billings to Medicaid and duplicate payments to service providers. The Commission's report, *Shifting Costs to Medicaid: The Case of Financing the OMRDD Comprehensive Case Management [CMCM] Program,* December 1995, cites CMCM as another example of efforts by OMRDD to compensate providers for perceived inadequate community residence funding, and recommends a re-examination of the state's role in the direct delivery of service and the adequacy of the methods used to finance services for persons with developmental disabilities.

CMCM is a discrete and separately-reimbursed service to a clinically-determined group of Medicaid-eligible developmentally disabled consumers residing in the community. It is supposed to assist them in locating and coordinating a group of needed additional services. While the program was intended to save the state money by shifting a portion of existing state-funded case management costs to Medicaid's 50 percent matching funds, the Commission's study found:

- CMCM fees for voluntary agencies were set at a rate higher than justified, amounting to $10.4 million in excess payment to providers for 1991-94;
- CMCM payments to community residence providers duplicated payments already in their rate for services performed by staff. OMRDD has not followed its own regulation requiring offsets equal to 50 percent of the CMCM payments (approximately $4 million) to partially compensate for duplications;
- after OMRDD implemented a new community residence fee methodology in 1993, duplicate overpayments continued, since the new fee does not deduct Medicaid CMCM payments of approximately $8.6 million a year;

- twenty-one percent of the sample of audited Medicaid claims for CMCM services either were for unallowable costs or lacked adequate documentation, suggesting that, if this pattern extended to the total claims filed, as much as $15.8 million in claims were ineligible for reimbursement from 1989-1994, and
- consumers residing at community residences were not allowed to choose case managers as required under federal law on the CMCM program.

The Commission determined the duplication of costs permitted under CMCM was largely driven by OMRDD's desire to supplement funding to community residences which had received no cost of living increases for several years. But, the Commission considers the improprieties under CMCM to be part of a long history of unorthodox methods by OMRDD of financing and supplementing programs and services to redress perceived inadequacies in funding. The Commission's report asserts that the net effect of these present and past efforts by OMRDD has been to circumvent the rate structure, undercutting respect for the validity of decisions made about financing the system, creating a climate which accepts and even sanctions circumvention.

*Medicaid claims for CMCM services either were for unallowable costs or lacked adequate documentation, suggesting that, if this pattern extended to the total claims filed, as much as $15.8 million in claims were ineligible for reimbursement from 1989-1994*

The report recommends elimination and recoupment of duplicate funding, establishing cost-based rates for voluntary providers reflecting true costs of CMCM services, clearer billing guidelines, and strengthened monitoring and oversight of the programs including requiring substantial case management experience to be qualified as a CMCM case manager and ensuring clients' free choice in choosing case management services.

*Nassau Herald,* December 21, 1995:

# Adult home administrator guilty

## *Former HAFTR executive director helps convict him*

**by Jeff Lipton**

The former administrator of an adult home, which was operated by the Hebrew Academy of the Five Towns and Rockaway, was found guilty last week of swindling a bank and stealing money from mentally handicapped residents of the home, authorities said.

A federal jury convicted Beryl Zyskind, 44, of Brooklyn, on a three-count indictment on December 13 for crimes he committed as the administrator of the Hi-Li Manor Home for Adults in Far Rockaway. The home houses about 120 residents, many with severe mental handicaps, officials said.

"It was the right result. It was the just result," said Ilene Jaroslaw, assistant United States attorney, who prosecuted the case. "This man was taking advantage of the most helpless people. He specifically targeted the weakest and most vulnerable people in his care to steal from."

Mr. Zyskind and David Kolatch of Woodmere, a former executive director of HAFTR, initially were both accused of diverting 40 percent of the home's revenues, officials said. But no charges were filed against Mr. Kolatch who turned federal witness and was guaranteed immunity from prosecution in exchange for his testimony, Ms. Jaroslaw said.


Rick Kopstein/HERALD

**Beryl Zyskind, who was convicted last week, was the administrator of the Hi-Li Manor Home for Adults, which was once owned by HAFTR.**

Mr. Kolatch tape-recorded conversations he had with Mr. Zyskind, which the court subpoenaed to use during trial and helped convict Mr. Zyskind on the first count of the indictment, she said.

Mr. Zyskind was convicted of defrauding the Village Savings Bank of Port Chester by obtaining a $1.2 million mortgage loan on the Hi-Li property, authorities said. He also was found guilty of embezzling $122,658 in veteran's disability benefits earmarked for a "mentally incompetent" resident of the home and stealing $40,000 from personal allowance accounts of the home's residents.

"The testimony showed that he targeted people who were so mentally incapacitated, those who were least likely to know what was going on," Ms. Jaroslaw said.

The conviction capped a two-year investigation by the State Commission on Quality of Care for the Mentally Disabled, which uncovered "seriously deficient conditions" at the home.

According to court testimony, in April 1989 Mr. Zyskind cheated the bank in connection with his purchase of the Hi-Li Manor. HAFTR owned the building until 1984 when it was sold to Mr. Zyskind and his wife, a sale which was partly financed by a $450,000 loan from HAFTR to him and secured by a mortgage on the property.

But HAFTR still held the home's operating license and Mr. Zyskind continued as the home's administrator. According to court testimony, he was granted the loan after forging the name of a former HAFTR president on a "subordination agreement" that he gave to the bank. . . .

# Enforcement Actions . . .

*A Commission investigation uncovered a $2.5 million fraudulent scheme whereby Dr. Easton personally instructed BPRI staff beginning in late 1984 to bill Medicaid for casual, non-therapeutic contacts between any BPRI employee and any client as though they were a therapeutic visit to the patient's residence. Thousands of such billings were submitted to Medicaid for simple and short wake-up calls to patients in the morning.*

## Adult Home Administrator Convicted

On December 13, 1995, based upon the investigative findings and referral of the Commission, a federal jury in Brooklyn, New York convicted Beryl Zyskind, the former administrator of HI-LI Manor Home for the Aged, located in Far Rockaway, New York, of bank fraud, embezzlement of a veteran's disability benefits, and stealing from the personal allowance accounts of the home's residents.

HI-LI Manor is a residence for approximately 120 persons, most of whom have been treated for mental disabilities and receive government assistance. The conviction is the climax of an extensive two-year investigation begun in 1990 when the Commission in its legislatively mandated adult home study (*Adult Homes Serving Residents with Mental Illness: A Study of Conditions, Services, and Regulation,* October 1990) found serious deficiencies in the care and treatment of the home's residents. The follow-up Commission investigation uncovered the diversion of millions of dollars in public funds intended for resident care (*Exploiting the Vulnerable: The Case of HI-LI Manor Home for the Aged and Regulation by the NYS Department of Social Services,* May 1992) and was referred to various enforcement agencies.

The indictment was obtained on March 2, 1995 by the Department of Justice's United States Attorney for the Eastern District of New York, Zachary W. Carter, based on the Commission referral.

Mr. Zyskind was convicted on three counts: (1) defrauding a bank by falsifying documents in refinancing his purchase of the HI-LI building and then diverting the proceeds of a $1.2 million loan from its stated purpose—improvements to the HI-LI property—into his own personal checking account, (2) embezzling for himself and his private businesses $122,658 in retroactive Veteran's Administration benefits to a mentally disabled Vietnam War veteran who had formerly resided at HI-Li and for whom Beryl Zyskind was appointed a fiduciary, and (3) embezzling tens of thousand of dollars from resident personal allowance accounts and covering up the fraud by systematically altering HI-LI Manor ledger cards reflecting the balance due each resident.

Mr. Zyskind faces up to 20 years in prison, a fine of $750,000, and could be ordered to make restitution to his victims when he is sentenced.

## Medical License Revoked Based on Finding of Medicaid Fraud

On January 12, 1995, the Administrative Review Board of the State Board for Professional Medical Conduct moved to revoke the medical license of Dr. Karl Easton. On April 11, 1995, in a related case, the New York Supreme Court, Appellate Division, First Department, unanimously dismissed Dr. Easton's appeal to halt this professional disciplinary hearing. In doing so, it affirmed a lower court's ruling that the previous (1992) finding of Dr. Easton's Medicaid fraud by the Appellate Division, Second Department, could by itself be a basis for finding a violation of professional medical conduct by the State Board without any requirement for a separate hearing on the issue and a relitigation of the underlying facts.

The revocation of Easton's medical license resulted from a Commission investigation, *Profit Making in Not-for-Profit Care: A Review of the Operations and Financial Practices of Brooklyn Psychosocial Rehabilitation Institute, Inc.* (BPRI), November 1986, which uncovered a $2.5 million fraudulent scheme whereby Dr. Easton personally instructed BPRI staff beginning in late 1984 to bill Medicaid for casual, non-therapeutic contacts between any BPRI employee and any client as though they were a therapeutic visit to the patient's residence. Thousands of such billings were submitted to Medicaid for simple and short wake-up calls to patients in the morning. The Department of Law, with fiscal analysis and

*New York Law Journal*, July 11, 1995:

# Corporate Veil Pierced In Reverse in Fraud

## *State Wins Right to Collect From Corporation*

**BY GARY SPENCER**

ALBANY—Piercing the corporate veil "in reverse" for the first time in New York, a Supreme Court judge has held two corporations liable for the $9.3 million debt of their president in a major Medicaid fraud case.

Karl Easton, a former psychiatrist who ran a private mental health program in Brooklyn until the state shut it down in 1986, is not a shareholder in either corporation, both of which are owned by his children. But Justice Joseph Harris of Albany said Dr. Easton had complete control of both corporations and used them to "conceal" and "launder" money fraudulently obtained from the state.

"Neither the corporate concept nor the corporate form was ever intended to enable the commission of the 'perfect crime,' " he said in *State of York v. Easton, No.* L-00238-93. He said the same rules that allow courts to hold owners liable for a corporate debt should allow courts to hold a corporation responsible for its officer's debt when necessary "to prevent fraud or to achieve equity."

Dr. Easton's Brooklyn Psychosocial Rehabilitation institute operated the state's largest community residence program for the mentally ill in the mid-1980s, until an investigation by the state Commission on Quality of Care for the Mentally Disabled accused him of "looting" millions of dollars in state Medicaid funds through fraudulent billings. . . .

testimony from Commission staff, sued Dr. Easton and the Easton family corporations for recovery of Medicaid money and treble damages. Judgment, in the amount of $7.5 million was rendered by a unanimous decision of the New York Appellate Division, Second Department which said that the state carried by "overwhelming evidence" the burden of proving that Dr. Easton fraudulently billed Medicaid for "home visits" that were not actually performed. Both New York State's highest court and the U.S. Supreme Court declined to hear an appeal from this ruling.

## Family Corporations Held Liable for Medicaid Fraud Debt

In a unique case, a state judge on June 28, 1995 ruled for the first time that corporations can be held "liable to the State of New York for their own illicit activity as well as that of their alter ego, Dr. Easton." State Attorney General Dennis C. Vacco in commenting on the new judicial precedent said that it "will provide the state with a significant tool in the battle against the nearly one billion dollar Medicaid fraud industry in New York State."

Supreme Court Justice Joseph Harris' decision cleared the way for the state to go after the assets of two real estate corporations owned by the children of Karl Easton, but over which he exercised complete domination and control to enable him to fraudulently obtain and conceal public Medicaid monies. Thus, the state can enforce the $7.5 million fraud judgment plus interest on this debt from the time of the July 6, 1992 judgment against him.

Karl Easton was the president of Cobble Hill Center Corp. and 3 Lafayette Avenue Corp. which collected grossly inflated rents from the BPRI properties through leases containing steep escalation clauses and provisions obligating the tenant to pay all taxes, expenses, repairs, etc. These so called "net-net" leases were not negotiated at "arm's length" because Easton himself was controlling the terms on both sides of the bargaining table. The state successfully argued that Easton attempted to erect a "corporate veil" behind which his personal transactions, obligations, and unlawful conduct could be concealed.

Corporate owners are generally not responsible for the debts of a corporation, although the courts have ruled that the corporate veil can be pierced to prevent fraud and money laundering. In some cases company owners can be held liable for corporate debts.

This case is unique because the corporation was found to be responsible for the personal debt of a company *officer.* The judge indicated that this is the first case of a "reverse piercing" of the corporate veil. He said the companies were shams and cleared the way for the state to go after the corporate assets which will fully satisfy the state's judgment.

The Commission is hopeful that the above enforcement actions stand as a deterrent to individuals who might be inclined to steal from vulnerable citizens in adult homes and other residential settings.

*During the past year the Commission received a national acknowledgement and award for its approach to quality assurance via the "Could This Happen In Your Program?" brochure series. . .*

# Accountability, Quality Assurance, and Assistance in Individual Cases

Approximately 1,400 calls for assistance monthly are received by the Commission on its 800 number. In addition, approximately 500 incident reports of possible abuse or neglect are faxed or mailed per month. Add to these another 175 or so cases per month of deaths in New York's mental hygiene system. Commission staff must sift through these reports carefully, determining which call for closer scrutiny and possible detailed investigation.

Some of the major Commission objectives in the review or investigation of these calls for assistance or reports are to:

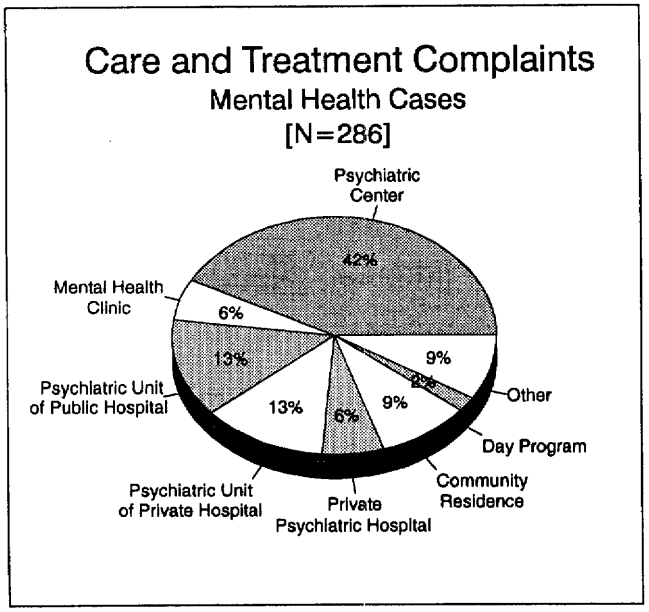
- provide direct interventions in cases which call for immediate attention, e.g., abusive situations;
- promote quality assurance in programs licensed or operated by New York State mental hygiene agencies;
- provide timely informed surrogate consent for medical treatment, when deemed necessary, through the Surrogate Decision-Making Program;
- prevent future deaths and abuse by learning from mistakes detected in death and abuse investigations; and
- suggest improved practices, procedures, and policies to agency providers, the mental hygiene offices, the New York State Legislature, and the Governor.

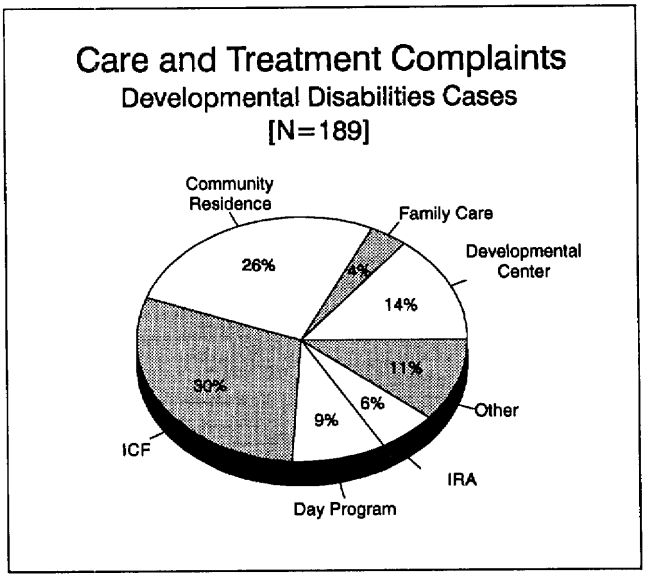
During the past year the Commission received a national acknowledgment and award for its approach to quality assurance via the "Could This Happen In Your Program?" brochure series, currently high in demand by providers and direct care staff throughout the country.

# Quality Assurance in Individual Care and Treatment Cases

The Commission's Quality Assurance Bureau reviewed care and treatment issues in 475 cases. These reviews were undertaken on behalf of individuals unable to resolve their issues with mental health or mental retardation programs. Approximately 60% of the cases involved mental health programs, with the largest number of concerns (42%) being expressed on behalf of persons in psychiatric centers. In contrast, reflecting the expansive community service system serving persons with mental retardation, only 14% of the cases concerned care in a developmental center. The remainder focused on issues related to community residential programs primarily and day programs to a far lesser extent. Also reflecting the dissimilarities in the two service systems, complaints regarding mental health services were made nearly as frequently by consumers themselves (90 complaints) as by family members and friends (113 complaints) on their behalf. Parents and staff made most of the complaints on behalf of persons with mental retardation (89 and 24 complaints respectively).

Regardless of who was calling the Commission for help, concerns related to basic issues such as medical care — including medication practices — the environment, use of personal funds and personal safety issues crossed program type and auspice.




## Medical Care

- The Commission received a complaint from a woman who was treated at an upstate psychiatric center that the Xanax she received was abruptly discontinued by her doctor, causing her to suffer withdrawal and rebound panic attacks. After reviewing the case, the Commission questioned the appropriateness of this order without a rationale, since it is commonly recommended that Xanax be slowly withdrawn to prevent withdrawal symptoms, seizures, and rebound panic attacks. The hospital responded by reinstating a system to monitor and evaluate physician documentation of medicine changes and by providing an in-service training for medical staff on the importance of documenting rationales for medication changes.
- A brother of a client requested the Commission to review the care and treatment his brother was receiving at an upstate OMRDD community residence. He indicated that his brother had experienced an increase of seizure activity due to a 30-pound weight gain and lack of medication adjustment. In investigating, the Commission found that staff were negligent in implementing the doctor's recommendations for monthly weight checks and providing a low-fat diet. They also failed to complete data collection regarding the client's personal hygiene goals. In response to the Commission's inquiry, corrective measures were taken which included staff retraining regarding data collection, goal implementation, and the physician's communication form. Internal quality assurance measures were put into place to moni-

tor the effectiveness of documentation and clients' medical care. Lastly, the individual's weight issue was re-addressed. A diet was formulated by the nurse working with staff to provide appropriate meal plans. The individual was also referred to the agency's nutrition classes.

- A case manager from a law project which advocates for mentally disabled individuals requested that the Commission evaluate the treatment one of his clients received while a patient at a state psychiatric center. Two weeks after his discharge the client's right leg was amputated. The Commission's review raised serious concerns. First, blood was not drawn for routine analysis until the fourth day of hospitalization at the center. No reasonable explanation or documentation could account for the delay. Lab results showed high blood sugar. Secondly, there were significant problems regarding his discharge from the psychiatric center to a local hospital for treatment for diabetes. A social worker stated she felt that the patient understood the need for treatment and that she had left the emergency room with the belief that he would be admitted shortly. Unfortunately, by leaving she failed to ensure that the patient would be treated in the hospital as specified in his discharge plan, an action required by state Mental Hygiene Law. Without the presence of the social worker, the patient left the hospital prior to admission. A week later his condition worsened, and he sought treatment at another hospital emergency room where he was immediately admitted. Despite aggressive efforts, his right leg was amputated.

  As a result of the Commission's review and findings, two significant policy/procedure changes occurred. First, the psychiatric center now requires that blood work be drawn within one business day of the order and requires documentation in the patient's record if a specimen is unable to be obtained for any reason. Secondly, social workers who escort patients from the psychiatric center to another inpatient facility are required to remain with the patient until they are admitted. Documentation of admission must be obtained and placed in the patient's record.

## Environment

- In a downstate community residence, a woman received third degree burns over 25 percent of her body and required multiple skin grafts and debridement at the area burn center. Her condition hovered between critical and guarded, and she developed pneumonia and septicemia. Her survival was long in doubt, and she ultimately died despite months of treatment in the burn unit.

  In cooperation with the Commission, the facility conducted an investigation which revealed that the burns were caused by a faulty system in the shower which failed to properly regulate water temperature. A plumber from an independent company found that the solenoid valve, which was designed to shut off the flow of water if the temperature rose above 110 degrees, was circumvented permitting the scalding hot water to proceed to the shower. Why this bypass was installed was undetermined, but the inquiry conjectured that a plumber or maintenance man may have inadvertently left the bypass open during the course of repairs.

  The facility took corrective action promptly. Residence staff were instructed to supervise residents during showers, and the malfunctioning valves were replaced. Anti-scald devices were installed throughout the residence. In response to Commission concerns, all the residences run by this agency were inspected by a licensed plumber to certify that temperature control mechanisms were in place (free from any bypass valves) and that all residents' showers had anti-scald devices. The Commission also requested the development of a policy banning the installation of any bypass system designed to circumvent water temperature controls.

- A Commission investigator made an unannounced visit to a community residence in response to a complaint by a resident about poor living conditions. Environmental problems were quite evident. The kitchen area was unkempt. All of the major appliances were dirty and the counter tops were cluttered with food particles and coffee grounds. In the bathroom, the toilet needed to be replaced, the bathtub caulked, and the walls needed plastering and painting. A review of bedrooms revealed that the residents were in need of additional assistance in maintaining their clothing and sleeping areas. Clothes were rolled up in balls, bed linens were stuffed in the closet, and beds were unmade. Additionally, the living room was heavily soiled, the windows had no curtains, and the blinds were in need of repair.

  Following the Commission visit, corrective actions were taken. The residence was thoroughly cleaned, rooms painted, and clothing and linens arranged in an orderly fashion. Repairs were made to the bathroom, and curtains and blinds were replaced in the living room. Staff

were instructed to make daily inspections and to work more intensely on service plan goals until residents developed the skills needed to maintain a clean and orderly environment.

- In response to a complaint by a mother about the care her daughter was receiving and the living conditions at an upstate community residence, the Commission made an unannounced visit. The visit confirmed the mother's allegations. The residence was dirty and the bathrooms were malodorous. The daughter's physical appearance was also quite poor. Her sweatshirt was stained, saliva dripped around her mouth, her toenails needed to be trimmed and her hair needed shampooing. Staff reported that the young woman's functioning had deteriorated: she reportedly had been hallucinating, wandering from the residence, and acting out. These behaviors prevented her from attending the day program and accompanying her peers on a long-planned trip. In addition, her medical care was problematic.

  The Commission recommended that the agency develop a plan to ensure that the residence is clean and odor free. Regarding the young woman, the Commission asked that her clothing be inspected to ensure that it was adequate and clean, her treatment plan be revised to include strategies to address her inappropriate behavior and personal hygiene, and the agency advocate for her return to the day program, and better coordinate her medical care.

  In response to Commission concerns, the agency conducted its own review and retained an engineer to do a physical plant assessment. This led to the hiring of a contractor to clean and renovate the entire house. Additionally, personnel were changed, including the hiring of a new program coordinator, and administration meetings were held with staff to identify environmental conditions and to ensure the maintenance of an acceptable living situation at the residence.

## Personal Fund Expenditures

- The Commission reviewed a facility investigation of the alleged misuse of residents' funds at a downstate ICF. The Commission expressed concerns that the internal review did not identify any systemic changes in the facility's monitoring of staff's handling of residents' funds and did not address the issue of reimbursement to residents. The report placed sole responsibility for the matter on the failure of the program supervisor to properly monitor purchases and inventories. With the encouragement of the Commission, the ICF made significant changes and established new policies to ensure the protection of client funds. These new procedures addressed SSI personal allowance funds, clothing inventories and purchases, SSI death benefits, client allowances, and recreational funds. Also, all supervisors and program directors were given in-service training to ensure the implementation of these new policies. The residents whose funds were mishandled were reimbursed for over $20,000.
- The Commission responded to a complaint filed by a brother of a consumer who was concerned that the family care provider was charging his brother for items that should have been provided without cost. The Commission review noted that such items as coffee, sugar, soap, mouthwash, linens and other items were purchased with personal allowance funds, an action forbidden by state regulations. As a result of the Commission review, a new account monitoring system was put into effect, a financial audit was conducted by the DDSO, and the consumer's account was reimbursed for the funds inappropriately expended for items deemed to have been the responsibility of the family care provider.

## Personal Safety Issues

- A family member called to complain that his 4'8" brother was the victim of frequent assaults by a 6'2" resident of the same ICF. The Commission investigation revealed that the aggressive client was in need of specialized treatment. During the course of the review, OMRDD took over the agency's operations and the aggressor was admitted to the hospital for psychiatric care. Upon his discharge, a new behavior plan was written, and at last report, his assaultive behavior had diminished significantly.
- A client's sister called to complain that her sister had suffered a number of unexplained injuries in her community residence, including a broken finger and toe. She also complained that another man had suffered a broken collar bone, the cause of which was unexplained. Commission investigation revealed that one of the residents was frequently aggressive—often pushing, slapping, or pinching other residents, but was without a behavior plan. Subsequent to Commission recommendation, a behavior plan was written for this individual. The complainant indicated that her sister was now more comfortable in the home.

- A mother called to complain that her daughter (a minor) was the victim of frequent bites and bruises, inflicted by the other children with whom she lived. Commission review revealed that in the first six months of the year, the child was the victim of 13 injuries which included bites, scratches, or cuts, of which only 3 were self-inflicted. Following the investigation, the child was moved to a unit housing children without histories of biting, activity groups were made smaller, a behavior log was started, and recreation staff have been required to work seven days a week to provide the youngsters with useful and enjoyable activities.
- As a result of a Commission review of adult abuse investigations involving a vulnerable woman in a psychiatric center, Commission staff decided to review her care and treatment. This review identified that in a six-month period of review, in addition to suffering abuse by staff on two occasions, she was also assaulted by other patients on nine other occasions. Unit staff informed the Commission investigator that the individual's provocative behavior toward other patients most likely resulted in their retaliating against her. Despite this clear indication of a serious problem, the treatment team failed to amend her treatment plan, establish a behavior plan, or implement any other interventions other than increasing the use of seclusion and PRN medication. As a result of Commission intervention, the woman's treatment plan was amended and a behavior plan established. A follow-up visit to the center found that she had shown significant improvement.

## Discharge

Concerns related to the aftermath of poorly planned and executed discharges and about the use of restraint and seclusion were common themes of mental health complaints. In fact, poor and sometimes disastrous discharges were alleged in 64 of the 286 mental health cases.

- A woman reported to the Commission that she was inappropriately discharged from the hospital when she failed to return on time for a pass and that she was not provided either prescriptions for medication or referrals for continued care. Following an investigation, the Commission found that the hospital had not allowed the patient to participate in her discharge and that she was discharged without a written plan in direct violation of Mental Hygiene Law. In response, the hospital indicated that the physician who treated the woman no longer had admission privileges.
- A 17-year-old woman who was six months pregnant was discharged from the Children and Youth Unit of a state psychiatric center. She was transported to Traveler's Aid where a case manager was to make arrangements for housing and follow-up services. Clinical records and the discharge summary indicated that the young woman was discharged to a local hospital—a fact later proved erroneous. In truth, she was discharged to Traveler's Aid with no services in place except a case manager—no residence, no medical or prenatal care, and no financial support. This discharge violated both the letter and intent of Mental Hygiene Law. In response to Commission concerns, the psychiatric center stated that several undocumented and unsuccessful attempts to provide linkages with appropriate community services had been made. The Center indicated that this discharge was not usual practice, and reviewed Commission concerns with clinical and administrative staff to prevent any recurrence of a similar situation.
- A woman contacted the Commission with concerns that she was discharged from the hospital without any medication or prescriptions, despite the fact that she had been taking several psychoactive medications during her hospitalization. She was readmitted to another hospital just four days after her discharge. A Commission review revealed that the attending psychiatrist had failed to instruct the patient on what medications to take and in what dosage, failed to share this information with her outpatient psychiatrist, and took no action to ensure that her anti-anxiety medication was not discontinued abruptly. In view of the seriousness of the findings, the Commission recommended that the hospital perform a six-month review of all of the psychiatrist's discharges of patients and, if necessary, take steps to ensure that the patients received proper instructions. Following its review, the hospital reported that the case in question was an isolated incident and did not represent a pattern of behavior.
- In response to complaints about discharge planning at a New York City hospital, Commission investigators conducted a two day review of nine patients which revealed serious, systemic deficiencies. Staff often failed to complete discharge summaries and consistently failed to send them and other relevant information to providers of outpatient services in a timely manner. Follow-up reviews of patients' subsequent inpatient hospitalizations and their outpatient care confirmed that patients were not psychiatrically stabilized prior to discharge or were

inadequately treated. In response to Commission findings, the hospital made significant changes in personnel and in treatment policy. These steps included closer scrutiny of patients to ensure an appropriate level of stabilization prior to discharge as well as better documentation of aftercare supports.

## Restraint & Seclusion

- A woman from a downstate psychiatric center complained to the Commission that staff gave her medication over her objection and put her in restraints for no apparent reason. A Commission investigation uncovered no behavior on the part of the patient that warranted either seclusion or, upon her refusal to go to the seclusion room, the doctor's STAT administration of medication and the use of four-point restraint for violent behavior. The investigation further found that staff failed to monitor the patient every 15 minutes as required by facility policy. The Commission cited the treatment team for its failure to employ restraint and seclusion only when *absolutely necessary* to protect the patient from injuring self or others and recommended in-service training for the ward staff and counseling for the doctor regarding the use of these interventions. In response, the facility implemented both recommendations.
- In reviewing the care and treatment of a patient in an upstate hospital, the Commission discovered the inadequacy of the hospital's Mental Health Unit's policies and practices governing seclusion. The patient in question, who is mentally retarded, was placed in seclusion. The Commission reminded the hospital that the use of seclusion for persons who are mentally retarded is forbidden by OMH regulations. The hospital responded by modifying its seclusion policy to exclude the use of seclusion with persons with mental retardation.

# Monitoring Adult Abuse and Neglect

The incident reporting regulations of both OMRDD and OMH (14 NYCRR part 624 and 524, respectively) require that programs operated or certified by these agencies report allegations of abuse and neglect to the Commission. In the report period, the Commission received 5,581 allegations. Each was reviewed by a Commission staff member and coded according to the seriousness of the incident. The most serious, coded R [Review Cases], are assigned to a Commission investigator who reviews the entire facility investigation (statements, medical reports, relevant clinical material, etc.) and the facility's corrective actions and sends a written critique to the agency. The Commission completed 455 of these detailed reviews. Commission staff follow less egregious but still serious allegations, coded S [Serious Cases], with phone calls to ensure that the individual is presently doing well and that corrective measures have been effective. The remainder of the cases [M–Monitor cases] are closed by the Commission based on summary information submitted by the agency, but remain in the Commission's abuse and neglect database for further reference and analysis when necessary.

A review of the types of allegations reveals that allegations of physical abuse were reported nearly twice as often as any other category of abuse. Verbal and psychological abuse allegations were also reported frequently. The equally high number of allegations of sexual abuse require explanation. Sexual abuse can be an allegation that a staff member had sexual contact with a client or patient. It can also be an allegation that two clients/patients engaged in sexual activity and one or both parties was not consenting—either

### Adult Abuse/Neglect Reports

July 1, 1994 - June 30, 1995

[N = 5,581]

| | OMH | OMRDD |
|---|---|---|
| **R**eview Cases | 90 | 365 |
| **S**erious | 38 | 306 |
| **M**onitor | 996 | 3,786 |
| **TOTAL** | 1,124 | 4,457 |

because the individual did not have the capacity to consent by reason of his/her cognitive deficits or one party was not a willing participant. As shown in the chart on the next page, these latter cases of client-to-client sexual abuse far outnumber the allegations of staff-to-client abuse.

The objectives of the Commission's adult abuse work include:

- promoting individual safety and effective care and treatment;
- ensuring that effective corrective measures are implemented; and
- improving the quality of agency investigations.

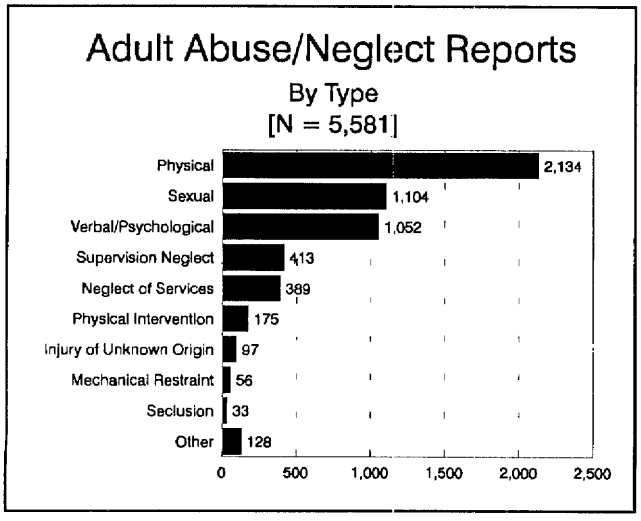
The vignettes that follow illustrate these objectives.

- The Commission received a report of the hospitalization of a 53-year-old woman due to her ingestion of a caustic cleaning product. The facility's investigation of this incident found no neglect by the family care provider, as she had left the cleaning bottle unattended for only a short time while she believed the client was sleeping.

  The Commission's review of the facility's investigation reached the same conclusion that no neglect had occurred, but the search of the Commission adult abuse database indicated that this was not the first incident of the individual ingesting a caustic substance. Further, Commission review found that the facility had not identified this behavior as a problem in her individual service plan. Commission concerns were shared with the facility, which concurred with the finding and revised the woman's treatment plan to ensure that proper safeguards were taken to protect her from further harm.

- In response to reports of multiple fractures occurring to an ICF resident, the Commission conducted a review of the procedures for handling, transferring, and positioning this non-ambulatory extremely frail individual. The Commission's review found that the ICF had implemented proper procedures for moving the woman and had created a log to document the name of the staff member performing the observation of the procedure by a medical staff member. However, review of the log found that staff were not entering their initials during several transfers and that there was no specific section of the log which indicated that a medical staff member was present during the transfer.

  The facility responded to the Commission's findings and took action to ensure that the procedures were implemented as intended.




*The objectives of the Commission's adult abuse work include:*

- *promoting individual safety and effective care and treatment;*
- *ensuring that effective corrective measures are implemented; and*
- *improving the quality of agency investigations.*

- The Commission's review of a facility's investigation of an allegation of physical abuse found substantive errors which failed to link the alleged perpetrator to the abuse, failed to note that two other staff had failed to arrange for immediate medical assistance for the injured man, and did not uncover the common practice of denying clients access to a telephone.

  In response, the Commission requested that the agency redo the investigation. The agency complied and found evidence to substantiate the allegation. The three staff involved were terminated from employment and the target employee was subsequently arrested and charged with assault in the third degree. Client access to the telephone was clearly identified as a right and not a privilege. In addition, the Commission's critique of the facility's initial investigation was incorporated into a plan of corrective action for the entire agency which emphasized that abuse would not be tolerated and that all staff needed to be mindful of how easy it was to dismiss a client's allegation of abuse based solely on the belief that the individual was "not credible."

- The Commission received a facility's investigation revealing that CPR administered by staff saved the life of a man choking on a sandwich. The investigation found

*The three staff involved were terminated from employment and the target employee was subsequently arrested and charged with assault in the third degree.*

no neglect by staff and concluded with a recommendation to commend staff for their quick lifesaving actions.

The Commission's review of this incident agreed with the recommendation to praise staff but also found that the investigation missed the significance of critical events prior to the client's choking and aspiration. Specifically, it was found that the man had returned to his ICF after ambulatory surgery requiring general anesthesia on the date in question. On the man's release from the hospital, ICF staff were instructed to contact the client's physician if excessive bleeding occurred and to restrict the man to light foods.

Staff offered the resident cookies and yogurt, consistent with the hospital instructions and consistent with his routine diet which called for chopped double portions. However, the man refused these foods, went to the refrigerator and, under staff supervision, took out a sandwich. After one bite of a peanut butter and jelly sandwich, he fell to the floor, became cyanotic and emergency CPR was initiated.

The error in judgment by staff in allowing the resident the sandwich was not discovered during the facility's investigation and was also missed by the facility's Incident Review Committee. After the Commission informed the agency of its findings, staff were provided with additional training.

## Sexual Abuse Reports

[N = 1104]

| | Intercourse | Other Sexual Activity |
|---|---|---|
| Staff-to-Client | 19 | 396 |
| Client-to-Client | 42 | 647 |

- An ICF resident was found with several abrasions on her upper body. It was determined by the facility that she was uncooperative while being escorted to the bathroom and most likely sustained the injuries when she "skidded along a carpet."

  The Commission's review of this incident found that there was no description of the type of escort used and no evaluation of whether the technique was an approved intervention.

  The facility responded to the Commission's findings and re-examined the target staff member's actions. After this second review, the facility took disciplinary action against three staff when it determined that the staff did not follow the resident's behavior program.

- The Commission received a report that two women who reside in an ICF had been abused by a male staff member. The reporting staff member, the house manager, stated she had been told of these allegations by another staff member who learned of them from a supervisor. An investigation followed, and the facility confirmed an allegation of verbal abuse and sought disciplinary action against the target staff. The facility concluded that an allegation of sexual abuse was unfounded but did find cause to discipline another staff who neglected residents while attending to a personal matter.

  Although the facility investigation appeared conscientious, the Commission's review found that the facility did not notify law enforcement of the allegation of sexual abuse, the facility did not discipline staff who failed to report the sexual abuse allegation, confusion among staff concerning the standards governing a male staff member assisting a female client with intimate personal care remained unaddressed, and personnel problems among staff had not been handled.

  The facility responded to the Commission's concerns and took disciplinary action and provided retraining for staff. In addition, the facility made personnel changes at the residence to foster a more stable environment.

- The Commission received a report from a day program that an ICF client alleged his black eye was sustained when he was "jumped" by four other residents of his ICF.

  The Commission requested further information relative to this report and discovered that the client's injuries were much more serious than reported, i.e., multiple bruises under both eyes, on the back of head and left cheek, and multiple contusions over neck, chest, arms

and back, including what appeared to be a complete sneaker print on his back.

The client's residential program's investigation of this incident found that a staff member had fraudulently completed an incident report concerning the client's injuries to cover up his having instructed four residents to join with him in beating the individual. The target staff member was terminated from his employment and two other staff members, who were found to have failed to follow agency policy relative to client injury, were disciplined. All staff in the residence were retrained on incident reporting procedures and increased supervision was provided to the residence.

Given the severity of the incident, the Commission requested that the injured client be granted the option to change residences since he might never feel safe or comfortable in the home. The Commission also focused the agency's attention on the finding that residence staff had not responded to the incident with outrage and concern. The facility shared Commission concerns and agreed to take further action if retraining did not correct staff attitudes.

# The SDMC Program: Accountability and Efficiency in Medical Care

Now in existence for ten years since its creation in 1985 as a demonstration program, the Surrogate Decision-Making Committee Program (SDMC) has handled 3,492 cases through June 30, 1995 in the 20-county area in which the program currently operates, providing timely informed consents regarding major medical treatment for individuals with mental disabilities residing in facilities licensed by state mental hygiene offices.

Avoiding the delays, inefficiencies, and costs of the alternative court processes, the SDMC program renders personalized and accountable decisions related to major medical treatment for individuals with mental disabilities, protecting their individual rights and best interests.

*The SDMC program renders personalized and accountable decisions related to major medical treatment for individuals with mental disabilities, protecting their individual rights and best interests.*

More than 300 dedicated volunteers serve on the SDMC panels, which must consist of a health care professional, a lawyer, a former patient or relative or advocate, and a person with expertise or interest in the care of persons with mental disabilities [The complete list of volunteer panel members is listed in the back of this report]. These volunteer panelists review applications for major medical treatment to determine whether the person is capable of providing informed consent in his/her behalf and, if not, whether there is an existing authorized surrogate to provide consent. If neither is found, the panelists provide substitute consent or refuse such treatment upon determination of the best interests of the individual.

During this reporting period, the SDMC panelists heard 344 cases, resulting in consents for 283 major medical treatments. Recent legislation authorizes the program to expand in an efficient and cost-effective manner by allowing the Commission to enter into agreements with local community dispute resolution centers. Under contract with the Commission, staff of these centers provide panelists with administrative support services.

Commission staff administer and oversee this innovative program by performing such responsibilities as recruiting and training panel members, conducting training for providers of care on the nature and timely processes of the program, reviewing and processing all applications for medical treatment, conducting outreach and information activities for health care providers, parents, spouses, and adult children of clients, guardians, and correspondents to clients, monitoring community dispute resolution center activities to ensure that dispute center staff provide panelists with quality support services, and providing legal assistance through the Commission counsel's office.

# Could This Happen in Your Program?

Over this past year, the Commission published seven brochures from its series "Could This Happen in Your Program?" Since its inception in the spring of 1994, 16 "teaching lessons" based on real-life situations have been published and made available free of charge to mental hygiene service agencies and all other interested groups or individuals. This brochure series received an award in the 1995 National Media Competition of the National Association of Mental Health Information Officers. Additionally, letters from around the country attest to the utility of the review and discussion provoked by the brochures.

This year's seven cases continued to illustrate necessary revisions and clarifications in policies, practices, and ways of thinking about situations to reduce the likelihood of similar tragic incidents. Abstracts [all names are pseudonyms]:

### In the Matter of Noah Paul: A Study in the Need for Improved Communication Concerning Individuals with Special Needs

#### The Case:

Mr. Paul, a 77-year-old severely mentally retarded man, was relatively healthy, however, he was hospitalized for a worsening leg infection and some preoperative tests for prostate cancer. His caregiver of ten years told staff about Mr. Paul's need for supervision during meals for eating too fast, but there was no documentation of this, only a nutritionist's note about cutting up Mr. Paul's food. On the third day, he was found unresponsive, having choked on his food. He was resuscitated, but developed aspiration pneumonia and congestive heart failure. His sister consented to a Do Not Resuscitate status; he died on the seventh day.

#### The Lesson

Mr.Paul's death can be directly related to a behavior or special need which either his caregiver did not adequately communicate to hospital personnel, or hospital staff did not sufficiently appreciate. In response to this tragic death, specific protocols were instituted to ensure that hospital staff are sufficiently aware of the total and/or special needs of the disabled person they are attending.

## Testimonials

*"Your concept is wonderful, and I believe will be very useful to our Community Support Teams and for ongoing staff and student training....Thank you for making these available to others in the field."*
- *Mental Health Provider*
  *New Hampshire*

*"What a great tool!"*
- *Program Coordinator*
  *Rehabilitation Program*

*"We are in the process of building a state of the art library devoted to developmental disabilities and believe 'Could This Happen in Your Program' would be an asset to have."*
- *DD Research Institute and Foundation*

*"We operate a residential and day program for individuals with developmental disabilities. As our program has grown ensuring quality care and protecting all of the people in our program has become more and more of a challenge. We are always searching for new ideas to help us improve our quality of care process, and feel that your new publication, 'Could This Happen in Your Program,' can help us achieve our goal."*
- *Coordinator of Program Development,*
  *Connecticut*

*"Thought provoking and a dramatic training source."*
- *Community Provider, Baltimore*

## In the Matter of Frieda Fleischman: A Study of the Interface Between Adult Homes and Mental Health Services

### The Case

In the fall of 1994, Ms. Fleischman was hospitalized with pneumonia for two weeks. Staff from the Home for Adults (HFA) noticed that she was withdrawn and appeared sad when she returned, although Ms. Fleischman denied these feelings. A month later she told her therapist she was feeling sad and hearing voices. Her psychotropic medication was increased, and her behavior began to improve, however, one month later she attempted to leave the residence in the middle of the night wearing only a housedress and no shoes. Staff stopped her, recorded the unusual behavior in the logbook but didn't inform the residence administrator or the outpatient mental health staff. The next morning Ms. Fleischman threw her medication in the garbage stating "What's the use of living?" and walked away. Again, administration and the outpatient staff weren't notified of her strange behavior. The day-shift staff were told about Ms. Fleischman's behavior, conducted a search for her which was unsuccessful, and notified the police. Her body was found on the beach several blocks from the residence; she had drowned.

### The Lesson

The residents of HFAs rely upon the open and clear communication between the paraprofessional staff at the HFA and clinical support staff provided by mental health service agencies for their sustenance in the community. There must also be a clear understanding among all staff about their respective roles and the special needs of the residents. Following Ms. Fleischman's death, outpatient staff reiterated their availability on a 24-hour-a-day basis to respond to crisis situations or offer advice to residential staff; residential staff were reminded of their duty and the means to notify supervisors and mental health officials when residents exhibit unusual behavior; and residential staff were provided training on signs and symptoms of possible decompensation which should trigger a set of notifications.

## In the Matter of Nancy Bauer: Untrained Staff + Lack of Readiness = The Formula for Disaster

### The Case

Ms. Bauer, a profoundly retarded, nonverbal woman who lived in a community residence, was prescribed a soft diet due to self-feeding and dentition difficulties. Two of the three direct care staff on duty one morning had only worked for the agency for three weeks. Circumstances arose that resulted in only one staff supervising nine residents during breakfast. This staffperson, unaware of Ms. Bauer's special diet, served her bite-size pieces of pancakes and sausage links and then left the area to get juice from the kitchen. She returned to see Ms. Bauer leave the table, go to the living room and put her head down. The second staffperson returned, saw that Ms. Bauer looked pale, and reported this to the next unit. Neither staffperson took Ms. Bauer's vital signs. The other unit staff arrived to find Ms. Bauer blue, without vital signs and, because they were told that Ms. Bauer had not eaten, they did not attempt the Heimlich maneuver, but did begin CPR. (Neither of the two new staff had been trained in the Heimlich or CPR.) A code was called, the local paramedics were summoned, and staff called for oxygen. The oxygen tank was empty, the emergency kit lacked CPR masks, and the paramedics were delayed because they couldn't locate the residence. Paramedics tried to intubate Ms. Bauer and found a 1/2 to 3/4 inch piece of sausage lodged in her mouth/throat. She did regain a pulse and respiration, however, she never regained consciousness and died several days later due to cerebral anoxia as a result of food aspiration.

### The Lesson

It took a preventable tragedy to teach an agency harsh lessons on many issues it took for granted. The facility realigned staffing patterns to ensure that at no time will more than one "trainee" be assigned to a unit each shift. Although they had not violated any policy, the minimal staffing level for mealtime was increased. The facility's orientation and training schedule was revised to ensure that trainees receive such training prior to assuming direct care responsibilities. The facility also instituted monthly checks of the availability and working order of emergency equipment.

## In the Matter of Cynthia Ashley: Death Follows Prescription Difficulties

### The Case

Ms. Ashley was voluntarily hospitalized for 17 days, and started on Haldol 2 mg. She was discharged and returned to work, however, she failed to keep clinic appointments and stopped taking her medications. Approximately eight weeks later, she attempted suicide by ingesting a bottle of aspirin, and was hospitalized a second time. She developed tremors, thought to be a side effect from the Haldol, so it was discontinued and replaced with Risperidone 2 mg daily, a

recently marketed antipsychotic medication which reportedly had fewer side effects. Continuing to improve and absent of suicidal ideation, she was discharged with prescriptions for Prozac 20 mg and Resperidone 2 mg daily and a scheduled outpatient appointment for the following week. At that appointment she told her therapist she did not take the Resperidone because the pharmacy she visited did not carry it. During his exam, he noted that she seemed paranoid and guarded but had no suicidal ideation, however, he checked off "yes" on the hospital's standardized Self Injury Inventory. At the end of the session, the therapist gave her a new prescription for Resperidone and an appointment for her next clinic visit.

She left the clinic, returned to her apartment building, went to the roof, and jumped to her death. A maintenance man in the building had interacted with her prior to her death and recalled that she stated she could not get her medication.

### The Lesson

Following the investigation into Ms. Ashley's death, the facility initiated corrective actions to address the prescription problem and the conflicting statements in her record concerning the possibility of suicidal ideation. Now, at the time of discharge, patients are instructed to call the prescribing psychiatrist if they have trouble filling the prescriptions upon release, and the psychiatrist is expected to call the preferred pharmacy to resolve any problem. If this fails, the psychiatrist is to fill the prescription at the hospital's pharmacy. Additionally, the hospital substantially modified the Self Injury Inventory to distinguish remote, recent, or current attempts or ideation of self-harm and the nature of the harmful behavior.

## In the Matter of Renee Curtin: Relaxed Vigilance Undercuts Standards of Care

### The Case

The Newell's family care home that Renee Curtin and another mentally retarded individual resided in caught fire on New Year's Day. Firefighters found Ms. Curtin lifeless in bed, with second- and third-degree burns to her face, trunk, and extremities. She was transported to a local hospital where she was pronounced dead. The fire investigation concluded that a kerosene heater in the laundry room below Ms. Curtin's bedroom, which Mrs. Newell said she used one or two days before the fire, was the most probable cause of the fire. According to family care regulations, the Newells never received the required special permission from the Commissioner to use a portable space heater. Additionally, monthly inspection reports for the past year, submitted by the case manager and co-signed by Mrs. Newell, indicated that no space heaters were used at the residence. It was discovered that the case manager did not make monthly site visits; she would bring a batch of monthly inspection reports to the Newells and have them sign the reports. The caseworker stated that it was her impression that as long as she "filed paperwork" with her supervisors they were happy; they never asked her whether she visited the home or what she saw when she visited.

### The Lesson

The case of Renee Curtin offers some lessons for programs struggling with the issue of monitoring the "monitors," particularly when their work requires out-of-office field activities, often to far-flung places. The agency promptly resurveyed the homes of this case manager, and instituted additional internal controls to reduce the likelihood of similar situations in the future. These controls included: amendments to the monthly inspection report to include a comment section on residents' activities during the site visit; monthly meetings between case managers and supervisors to discuss each home's status; yearly visits to the homes by the supervisory staff; and random audits of case managers' site visit schedules, reports, travel vouchers, billings, and statements of state vehicle use on a monthly basis to ensure visits occurred as planned/required.

## In the Matter of Bonnie Johnson: Hot Water System with Malfunctioning Temperature Control Causes Life-Threatening Burns

### The Case

Bonnie Johnson, a 63-year-old mildly mentally retarded woman, took a shower, inadvertently turned the control the wrong way, and the water got too hot. Suffering third-degree burns over 25 percent of her body, she had skin grafts and surgical debridement, had been on and off a respirator, placed on nasogastric tube feeding, had multiple blood transfusions, and had an endoscopy. She also had both pneumonia and septicemia; the septicemia persisted and the prognosis for her continued survival was uncertain. The investigation found that there were no regular checks of the system to regulate water temperature, including the mixing valve and water shut off valve. There were other scalding incidents the Commission has encountered when temperature-control equipment has failed.

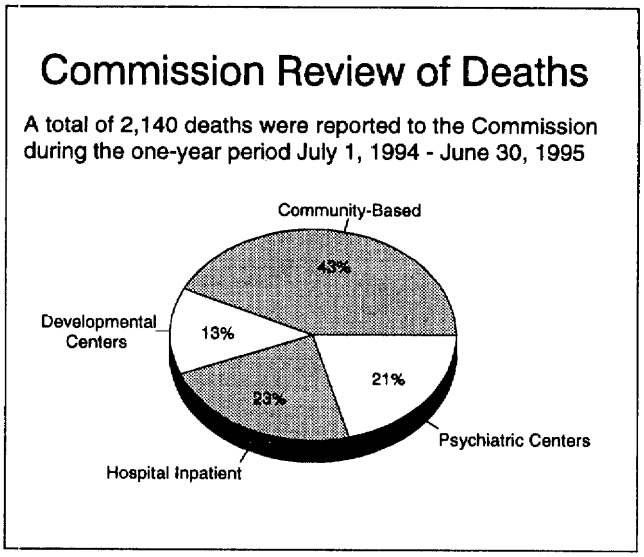
## The Lesson

No one solution or set of equipment can safeguard all residents from scalding injuries, however, some recommendations can help managers and administrators reduce the possibility of such injuries. Several low-cost steps can be taken to assure that the equipment is in good working order: train direct care staff to report instances of water too hot for comfort; equip residences with a thermometer and assign weekly temperature checks/recordings; schedule regular (at least annual) maintenance checks on the hot water system; if a bypass of temperature-control devices has been installed for repair work, the closed position should be secured and only authorized staff given access to open it; and where extra protection is needed, providers should consider installing shower head devices that interrupt the flow of water if the temperature becomes hot enough to scald.

## In the Matter of Jesse Caron: Lessons for Agency Administrators and Direct Care Staff on Abuse Cover-Up

### The Case

Jesse Caron reported to his sheltered workshop with his left eye black and blue, and almost swollen shut; the white of the eye was completely bloodshot. He told workshop staff that a residential staff member punched him in the face. The residence investigation concluded that although the staff person had changed his story and said he may have accidently struck Mr. Caron during a restraint, there was insufficient evidence that Mr. Caron was the victim of abuse. The Commission requested that the agency reopen the case, which it did, and found that the staff person hit Mr. Caron in the face and chest, and then restrained Mr. Caron with the help of another staffperson. The residence manager was told of the incident, and he instructed the two staff to report that Mr. Caron hit his face on a doorknob.




### The Lesson

Agency administrators must take care to objectively collect, analyze, and weigh evidence in client abuse cases, particularly when the only testimony is from the victim and the alleged perpetrator. Early involvement with law enforcement authorities in abuse investigations can assist agencies in maintaining objectivity, communicate to all parties the seriousness the agency attaches to the allegations, and lead to the quick resolution of charges. Direct care staff must reflect on the degree to which they will go to "help" a fellow worker. They need to consider the consequences to their own careers as well as the health and well being of the individuals they serve when they are tempted to cover for their peers' mistakes. Finally, a simple request to make a telephone call was denied by residential staff, and triggered a chain of events: assault, serious client injury, conspiracy, the termination of three employees, and the arrest of one.

*Monitoring the care of children in the mental hygiene system is a particularly important Commission function which includes oversight in their care, treatment, abuse, and deaths.*

# Watching Over the Children

Monitoring the care of children in the mental hygiene system is a particularly important Commission function which includes oversight in their care, treatment, abuse, and deaths. During the past year, the Commission did a special analysis, with follow-up recommendations to the Office of Mental Health, on the (over)use of restraint and seclusion in children's psychiatric programs. A series of articles presenting various sides to the controversial issue of "facilitated communication," a potential means of communication between developmentally disabled children (and adults), especially those who are autistic, appeared in the Commission's newsletter. Commission interest on this issue arose from the question of the legitimate use of this means in situations of alleged physical and sexual abuse. The Commission also continues its assistance to families in meeting the special needs of their infants and toddlers with disabilities in conjunction with the New York State Department of Health's Early Intervention Program.

# Monitoring Children's Care: State Central Register Allegations

Pursuant to New York State's Child Abuse Prevention Act of 1985, the Commission receives reports of allegations of child abuse/neglect from the State Central Register. The Commission opened 137 investigations of alleged abuse/neglect in 1995 in residential programs operated or certified by the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities.

The Commission investigates and makes a recommendation to the Department of Social Services within 60 days to unfound or to indicate a case. A case which is indicated is one in which there is credible evidence that the child(ren) has been harmed (as defined by Social Services Law) or placed at substantial risk of harm by a custodian through other than accidental means.

Figure 1 shows that the Commission opened 137 cases during the report period with slightly over two-thirds of the reports coming from OMH operated or certified programs. More than half of the OMH reports came from the state-operated programs — the children's psychiatric centers and the children and youth units of adult psychiatric centers. This is generally consistent with reporting trends from other years.

**Figure 1: SCR Child Abuse Cases Opened**
**July 1, 1994 - June 30, 1995**

| OMH | | OMR | |
|---|---|---|---|
| CPC | 45 | CR | 3 |
| CR | 5 | DC | 2 |
| CYU | 11 | ICF | 27 |
| Art. 28 hosp. | 7 | IRA | 6 |
| Art. 31 hosp. | 7 | PS | 1 |
| RTF | 19 | Other | 2 |
| Other | 2 | | |
| Total | 96 | | 41 |

CPC = children's psychiatric center
CR = community residence
CYU = children and youth unit of psychiatric center
ICF = intermediate care facility
DC = developmental center
IRA = individualized residential arrangement
RTF = residential treatment facility
PS = private school

**Figure 2: SCR Child Abuse Cases by Type**

| | OMH | OMR |
|---|---|---|
| Physical Abuse | 37 | 23 |
| Misuse of Restraint | 24 | 3 |
| Sexual Abuse | 17 | 4 |
| Supervision Neglect | 15 | 9 |
| Neglect of Services | 2 | 2 |
| Misuse of Seclusion | 1 | 0 |

As revealed in Figure 2, allegations cover a number of situations. For example, 44% of the cases alleged physical abuse of a child(ren) by an adult. These are typically allegations that a custodian has hit, kicked, or otherwise inflicted an injury on the child. Twenty seven (20%) of the cases alleged the misuse of restraint. This category of allegation covers a number of situations. In psychiatric settings where the use of 4-point restraint is permissible to stop a child from injuring himself or others, such an allegation may arise when the restraint is used unnecessarily or unduly roughly. It may also be used to describe take-down procedures that result in injury to the child. These are specific techniques for holding a youth until he/she calms that minimize the risk of injury. If unauthorized techniques are used, e.g., choke holds or wrestling holds, or an approved technique is applied with undue force, an allegation of the misuse of restraint may be forthcoming. The failure to maintain prescribed levels of supervision for children may result in a variety of incidents that harm or place a child at substantial risk of harm: suicidal children may hurt themselves, children may sexually or physically victimize other youths, and children may run away or wander off and be victimized in the community.

In 29 of the 147 cases the Commission closed in the report period, the Commission found evidence of abuse/neglect (as defined by Social Services Law) and recommended to the Department of Social Services that the case be indicated (See Figure 3). In the remaining 80% of the cases there was insufficient or no evidence of abuse/neglect. For example, the child may have sustained no injury or a very minor one, an injury may have been sustained accidentally, or the investigation was not successful in identifying the perpetrator of the abuse/neglect.

**Figure 3:**
**SCR Child Abuse Case Determinations**

| | OMH | OMR |
|---|---|---|
| Indicated Cases | 19 | 10 |
| Unfounded Cases | 82 | 36 |

The investigations of child abuse cases afford Commission staff the opportunity to visit the children's programs, interview the children and staff, review the youths' records and thereby hear the stories of the repeated victimization of many of the children. These children have suffered repeated physical and sexual abuse in their homes over many years. Many have known only seriously deficient parenting from mothers and fathers who are seriously mentally ill or addicted to drugs or alcohol or too physically ill to care for them. This makes it imperative that the Commission's abuse/neglect investigations on behalf of these children do more than just determine whether a particular incident was abusive. Rather, we need to determine what can be done to make these children safe while they are in the care of New York State's mental hygiene system. Thus, at the conclusion of nearly one third of the investigations, the Commission makes recommendations for corrective actions that had not been identified by the facility. The Commission requests a written response, and Commission staff check for implementation of the measures when they make later visits to the facility.

## Case Examples

- At the conclusion of the Commission investigation, a child's allegation that she was fondled by a teacher in a private psychiatric hospital's school program was not supported by credible evidence. The Commission investigation, however, found there were unnecessary delays in reporting the allegation to the SCR, and the facility had failed to separate the teacher from the child as promised until the Commission intervened a second time. The hospital revised its policies regarding the reporting of abuse allegations and the reassignment of targeted employees.
- In investigating an unfounded allegation that a child with mental retardation who regularly engages in self-abusive behaviors was improperly restrained by staff, the Commission could not determine the origin of the child's injuries. The child's self-abusive behaviors had resulted in similar injuries in the past. The child could tell Commission staff nothing about the injuries, and there were no witnesses. However, the Commission investigation revealed that the child's behavioral intervention plan was outdated and data was kept inaccurately and inconsistently. In response to Commission recommendation, the facility agreed to revise this plan and also insure that the psychologist regularly reviews the program and its implementation.
- Alleged sexual activity involving three residents raised concerns about the adequacy of staff supervision at a developmental center. The investigation revealed that the supervision policy did not clearly define "close supervision." Although staff were, in fact, not providing the level of supervision intended, they were providing supervision as they understood developmental center policy and practice. Thus, the Commission found no breach of duty and the case was unfounded. As a result of Commission recommendations, residents received sexuality training and counseling, and the policy defining close supervision was revised.
- Investigation of the escape of three residents from a children's psychiatric center revealed a facility-wide failure to complete security and environmental checks as required. This permitted three adolescent girls to escape through a bedroom window. They were picked up by a taxi driver who took them to his house for several days of sex and drugs. The Commission recommended that the staff member who had failed to do the environmental checks, which would have identified the unsecured window screens, and failed to perform the 15-minute checks of the patients, be indicated. In addition, the facility took immediate action to ensure the safety of the youngsters in its care.
- Two children received the wrong medication when an IRA staff member pre-poured medication and left the administration to a staff member who had no medication training. Neither youngster was harmed nor placed at risk of harm, so the case was unfounded. Nonetheless, on the recommendation of the Commission, the agency agreed to mandate additional training, including a medication certification course, for all per diem staff.
- An adolescent female in a private psychiatric hospital alleged that during the late evening, a staff member and she had oral sex. The Commission investigation revealed that the youngster's seriously discrepant versions of the events in question and the employee's unblem-

ished work record provided insufficient credible evidence to support the allegation. Commission review also revealed that the hospital's regular violation of its own rule to have two staff on a unit at all times had placed both the patients and the single staff member at risk. The hospital agreed to reissue the staffing policy and monitor its implementation.

- In an indicated case, a staff member in a community residence for mentally retarded persons breached his duty and caused injury to a child when he repeatedly used excessive force and non-approved restraining techniques that placed a child at substantial risk of choking. The absence of supervisory staff on the second and third shift permitted the development of an abusive environment. The agency responded to the Commission deficiency findings by reconfiguring its management structure, ensuring the presence of unscheduled, but frequent, visits by senior administrators on the second and third shifts. Retraining in the management of children with behavioral problems was provided to all staff.

## Restraint & Seclusion in Children's Programs

A Commission analysis found that restraint and seclusion use among children's psychiatric programs is significantly higher than in adult psychiatric programs. The analysis of 40 children's psychiatric programs included all state-operated psychiatric facilities (14), all state-licensed children's psychiatric units in general hospitals (16), and programs in private psychiatric hospitals (10) in operation in September 1992.

The data showed that in September 1992 children served in New York psychiatric programs were four times more likely to be secluded and almost twice as likely to be restrained as adult patients. Similarly, the number of seclusion orders per 100 children was six times higher than the number of seclusion orders per 100 adults statewide; and the number of restraint orders per 100 children was one and one-half times higher than the number of restraint orders per 100 adults [see chart].

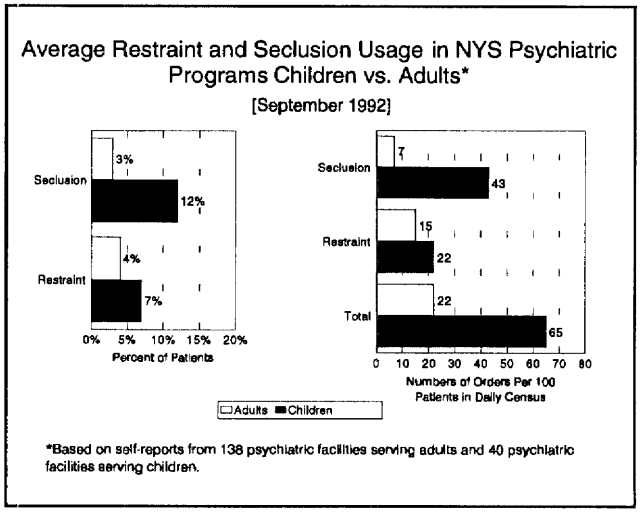
These high rates represent the statewide average for children. On the positive side, a significant percentage of New York's psychiatric programs serving children did not use restraint or seclusion at all during the period studied—half made no use of seclusion with children, and 43 percent made no use of restraint. Ten of the 40 facilities reported no use of either restraint or seclusion with children during the month studied.

Among the significant findings:

- as a group, private psychiatric hospitals used restraint and seclusion with children less often than other types of facilities
- restraint and seclusion usage with children was markedly higher at the separately administered state children's psychiatric centers than at state children and youth psychiatric units under the umbrella administration of co-located state adult psychiatric centers
- high use of restraint and seclusion in "high-user facilities" included not only more frequent use of the interventions, but also use with *more* children
- with the exception of gender (higher rate for boys) variations in restraint and seclusion rates were not directly associated with differences in the children served (e.g., age, race, substance abuse), nor in the size or location of a facility (upstate vs. downstate)

Since the release of the Commission's studies on restraint and seclusion, the NYS Office of Mental Health has taken several actions related to the use of restraint and seclusion. In 1994 the OMH Restraint and Seclusion Task Force released its "Final Recommendations on the Use of Restraint and Seclusion," and in November 1995, OMH promulgated revised policies (PC-701) governing the use of these interventions in state-operated programs.

Important changes in the revised policies have a direct impact on the use of these interventions with children. The rationale for restraining a patient who is known or suspected to have a history of physical or sexual abuse must be documented as a part of the assessment process. The use of restraint or seclusion with children under the age of *nine* may only be authorized by the Chief Medical Officer of OMH or a designee, and the maximum allowable time period for or-



ders for either intervention are limited to *one hour* for patients aged nine through 17, and *30 minutes* for patients under the age of nine.

In the Commission's third report on restraint and seclusion, *Governance of Restraint and Seclusion Practices by NYS Law, Regulation, and Policy* [see above], the Commission issued a series of "Guiding Principles for the Use of Restraint and Seclusion." These recommendations addressed the needs of special populations in all psychiatric programs, and proposed that seclusion should be prohibited for children under the age of 13 and orders for either intervention should be restricted to one hour for children.

# Facilitated Communication

Facilitated communication (FC) has been defined as "a method of facilitating expressive communication...by supporting the communicator's hand, wrist, elbow, or shoulder, and providing backward resistance to assist the individual in selecting letters on a letter board, typewriter, computer using a word processing program, or a small, portable computer" [M.D.Smith & R.G. Belcher, *Journal of Autism and Developmental Disorders* 23 (1993)]. As a potential means of communication between developmentally disabled persons, especially those who are autistic, the authenticity of facilitated communication as a legitimate means of communication could have tremendous implications in modes of interaction with these individuals and, especially, in situations of alleged physical and sexual abuse [why the Commission became seriously interested].

A series of articles presenting various sides to the controversial issue appeared in the Commission's newsletter, *Quality of Care* (Issue 62, January-February 1995). Commission staffperson Natalie Russo's article explored: What is facilitated communication, and why is it so controversial? What evidence supports or disproves this method of communication? and, How is it being used? Commission Counsel Paul Stavis' article asked, "Can it Produce Evidence?" Two other articles offered perspectives from parents (Sue Lehr) and program staff (Doug Wheeler). The Commission Chairman provided an editorial reaction and comment.

## Facilitated Communication: History/Controversy

Working in Australia during the 1970s, Rosemary Crossley, developed facilitated communication initially to assist people with cerebral palsy communicate. Dr. Douglas Biklen of Syracuse University, brought the technique to the United States in the 1980s, and popularized its use with individuals with disabilities, most notably autism.

Some proponents of facilitated communication hold the belief that a person does not have mental retardation, rather, under the surface of the autism, the person has full cognitive faculties. Nonsupporters would say facilitated communication is a self-fulfilling prophecy—the facilitator wants to believe that the person with a severe cognitive and language disability is actually of normal to superior intellectual ability. Parents especially want to believe this; facilitated communication could finally be the way to unlock the door to their son or daughter's mind.

Part of the controversy surrounding facilitated communication stems from the question of who is actually doing the communicating—facilitator or communicator. Validity testing of the technique has been frowned upon by proponents, who argue that such testing would undermine the confidence of the communicator, place undue pressure on him/her, and introduce negativism that would destroy the communicative exchange. According to a review of the literature, most support for facilitated communication is based on anecdotal reports.

Advocates for the technique say there is no harm in trying facilitated communication, however, opponents argue that "false communication" may distort beliefs, understanding, and rehabilitative approaches to persons with autism and other developmental disabilities. Additionally, in the past few years, facilitated communication has been the source of many contested abuse allegations, usually allegedly reported by an individual with very limited unassisted communication skills, against a family caregiver or caregivers.

## Facilitated Communication: Its Role in the Judicial System

The law and courts became interested in this technique because, if it is proven scientifically reliable, individuals who were previously unable to communicate would now have the ability to make their own decisions about medical care, give testimony in support of their legal interests, and provide testimonial evidence to prosecute crimes, especially when they may have been the only witness.

Paul Stavis' article discussed four legal decisions which have faced the question of the evidentiary validity of facilitated communication. Two have refused to admit out-of-court statements obtained through facilitated communication. Two others have permitted its validity to be judged by direct observation of the court or a jury. Apparently, the uses of facilitated

communication in court will have to be judged on a case-by-case basis until further knowledge is accumulated.

## The Parents' Perspective

According to Sue Lehr, one of the most dramatic aspects of facilitated communication was that parents had to look at their children in a different way; they had to learn more about their children as a individuals with likes, dislikes, wants, needs, and goals, rather than only what their disabilities were. Facilitated communication also changed the way parents talked to and interacted with their children. Finally, because their children were perceived by themselves and others as being more competent, intelligent, and capable, new opportunities arose which led to more experiences and achievements. This new way of interacting with their sons and daughters also meant that parents faced certain dilemmas and challenges in meeting their children's newly communicated needs and expectations.

## Program Staff's Perspective

During 1991, O.D. Heck's Autism Program learned about Dr. Biklen's work in facilitated communication and enthusiastically joined in learning the technique. By the end of that year, all staff—clinical, supervisors, and direct care—had been trained, and many were actively using the facilitated communication technique with about 20 individuals from the Autism Program.

The impact of introducing this new method of communication was tremendous for both the care and treatment of the individuals in the program as well as the staff who were beginning to fall into two categories—"believers" and "nonbelievers." Individual-level impacts included: major changes in medical treatment or the need for more invasive diagnostic procedures; potential changes in staffing assignments; and changes in treatment and program planning. Impacts on staff included: confrontational situations with personnel who were "nonbelievers;" skeptical administrative staff who wanted usage restrictions; and, medical staff not readily accepting FC messages. It was clear to O.D. Heck staff that they themselves had to objectively validate FC if it was going to be used in the Autism Program.

A research committee was formed, and great care was taken in planning a research study design on which everyone agreed. Facilitators would be "blind" to the photographs that the students would see, and the interactions and environment was designed to keep the student as comfortable as possible. The results were shattering.

After three months, running hundreds of trials with 12 students and 9 facilitators, there was not one single correct response. There was overwhelming evidence of facilitator influence, albeit unconscious. Facilitators were devastated, as expected because of their emotional investment in the technique; however, after a period of time, they came to their own conclusions about FC. Reaction to the results of the published study had also been "intense and overwhelming." Correspondence came from all over the world: families who were torn apart because of abuse allegations; fathers who were in jail because of allegations; mothers whose

## Commission Data

Since 1992, the Commission received 21 allegations of adult abuse that were produced by facilitated communication. The majority of the reports (16) were from community residential or day programs located in upstate New York. Of the 21 allegations, there were 9 reports of physical abuse, 8 reports of sexual abuse, 3 reports of neglect, and 1 report of psychological abuse.

Characteristically, the alleged incident involved male victims (12) and perpetrators who were either employees (10) or peers (5). In all allegations (21), there were either no physical injuries or only minor physical injuries. For the remaining three allegations, the extent of the victims' injuries were unknown.

Alleged abuses included the following incidents:

- An individual alleged that his teacher had repeatedly performed oral sex on him over a period of 9 years.
- An individual alleged that a staff person hit him.
- An individual alleged that he is left home alone when he is sick, he never receives breakfast, and is hit and verbally abused when he expresses his needs.
- An individual alleged that her brother-in-law touched her vagina and breasts.

Of the 18 allegations that have been reviewed and investigated, 12 were "unfounded," 5 were "inconclusive," and only 1 case was "confirmed." Most often, allegations were unfounded because of lack of evidence, the incident was not possible (e.g., the alleged perpetrator was not working on the day of the incident), or a lack of credible witnesses.

children had been placed in foster care; and professional staff who had been "ostracized" for not believing.

According to Doug Wheeler, since his study, there have been some 25 other studies that confirm O.D. Heck's findings. There has not been any objective evidence to confirm that facilitated communication is a legitimate technique for communication.

The Commission Chairman concluded in his commentary: "I recall watching the 'Frontline' program on facilitated communication which 'exposed' its unreliability. Two images remain with me. In one, I saw staff at the O.D. Heck Autism Unit actively engaged with the residents as they conversed with them through FC. It was a level of interaction I have rarely seen in an institutional setting. In the second, after the study had ended and staff had abandoned FC, I saw residents walking down corridors and being escorted by staff in a scene that seemed to have transported residents and staff back through time. I was left with the nagging question: Is the interaction itself worth it notwithstanding the doubts about the authenticity of the communication?"

## Early Intervention for Infants and Toddlers with Disabilities

As a result of legislation passed in 1992, New York State implemented a statewide system to assist families of infants and toddlers (from birth to age three) with disabilities in obtaining appropriate services to enhance the development of their children and support the efforts of families in meeting the special needs of their infants and toddlers. The Commission has assisted the New York State Department of Health, which serves as the lead agency for the program, in the development of a statewide Early Intervention Program by promoting the active involvement of families in this program.

In recognition of the essential role that families play in planning and overseeing the provision of early intervention services, the Department of Health and the Commission have established a Parent Training and Advocacy Project. This demonstration project is designed to explain the availability and benefits of the Early Intervention Program, and to provide families with information and technical assistance to ensure their understanding of the rights of their children under this program. This project utilizes both Commission staff and three designated contract offices of the Commission under its Protection and Advocacy Program for Persons with Developmental Disabilities. The contract offices participating in this project are Western New York Advocacy for the Developmentally Disabled, Disabilities Law Clinic at Albany Law School, and Westchester/Putnam Legal Services. Through this project, the Commission provides parents with an independent resource for information and technical assistance to empower parents to play an active role in the Early Intervention Program, and to ensure that the services provided maximize the developmental potential of their children with special needs.

*As a result of this Early Intervention Mediation Training Program, families will have access to an impartial and non-adversarial system to resolve problems or concerns regarding the Early Intervention Program.*

Under the federal law which authorizes the establishment of the Early Intervention Program, parents are to be provided with a formal impartial hearing system in order to resolve complaints. Unlike the federal law, New York State also affords parents the opportunity to resolve problems through a mediation program designed to provide parents with a non-adversarial complaint process. In order to ensure that such services are available, the Department of Health requested the Commission, in collaboration with NYS Association of Community Dispute Resolution Centers, to conduct a training program for mediators for the Early Intervention Program. The Commission was given primary responsibility for the development and conduct of the training sessions with logistical support services provided by the NYS Association of Community Dispute Resolution Centers. The training included panel members representing parents, county, early intervention officials, and early intervention service providers.

During this past year, the Commission conducted training sessions on Long Island and Syracuse for 43 mediators. As a result of these trainings and similar trainings conducted last year, a total of 110 mediators have received this specialized training in the Early Intervention Program. As a result of this Early Intervention Mediation Training Program, families will have access to an impartial and non-adversarial system to resolve problems or concerns regarding the Early Intervention Program.

*With a proven reputation for vigorous independent monitoring and advocacy, the Commission was entrusted with the administration of these federal programs.*

# Protection and Advocacy in a Diverse System of Change and Transition

The Commission administers a network of protection and advocacy programs which were created by Congress to ensure that individuals with disabilities, vulnerable to abuse and neglect, would be protected and guaranteed constitutional rights. With a proven reputation for vigorous independent monitoring and advocacy, the Commission was entrusted with the administration of these federal programs.

A particular strength of the protection and advocacy network of services is the statewide accessibility to these services made possible via the contracts with private, regional offices. The network's effectiveness continues to add to a track record of individual assistance, technical assistance, and legal representation of people with disabilities.

# Protection and Advocacy for Persons with Developmental Disabilities

The New York State Protection and Advocacy for Persons with Developmental Disabilities (PADD) program served 27,254 New York State citizens with developmental disabilities this past year, an increase of 3,254 from the previous year. These services included legal assistance and nonlegal individual advocacy, and encompassed a variety of educational and training programs and special efforts fostering community integration of persons with disabilities.

The Commission administers the PADD program from its central office in Albany through contract with private, nonprofit legal services and advocacy agencies. Services range from legal representation to nonlegal assistance and include training opportunities and informational materials. Included among the specific services during the past year were: case advocacy services to 2,060 individuals, training for over 9,900 individuals, class action litigation representing approximately 4,200 persons, non-litigation group advocacy for 1,000 individuals, abuse and neglect reviews in 4,778 cases, and over 5,300 responses to requests for information, materials, referrals, and technical assistance services.

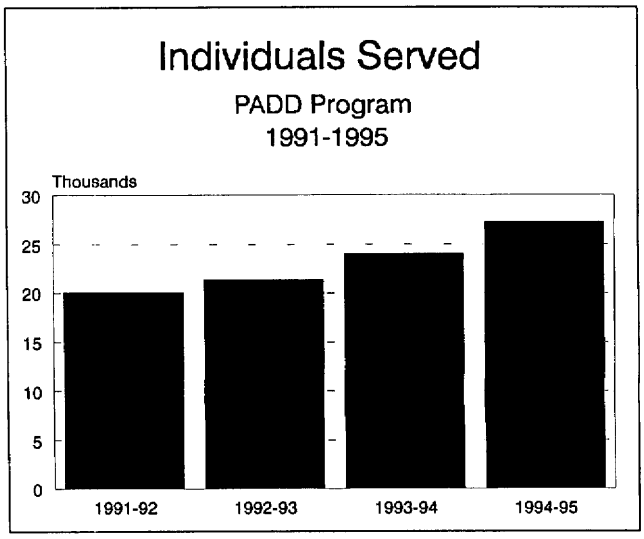
The following case examples illustrate individual PADD program achievements.

## Adoption of Children with Severe Disabilities

There is a shortage of families willing to adopt children with disabilities and, when the process is fraught with difficulties, the incentive diminishes. The PADD NYC outreach office was instrumental in assisting an adoptive family in retaining Medicaid benefits for their adoptive child with Fetal Alcohol Syndrome. The family had relocated from California where they had received MediCal benefits for the child. However, the New York Medicaid officials had denied New York State Medicaid for the family, indicating that the family income was above the legal threshold. After checking with the state of California, the PADD NYC advocate was able to cite the relevant federal Medicaid regulations on adoption of children with disabilities. With the additional legal opinion from the PADD legal support unit, New York Lawyers for the Public Interest, Medicaid officials were convinced that benefits could be granted under an applicable waiver. Subsidized adoptions are crucial for the permanent placement of children with severe disabilities. Denial of benefits to this family may have caused the placement of the child in a more costly and certainly less-homelike environment.

## Private School Placement for an Indigent Child

The PADD program in White Plains, Westchester/Putnam Legal Services (WPLS), won a rather routine state review officer decision, but in so doing, helped establish a method for poor people to gain placement in a non-state-approved private residential school. As a result of the US Supreme Court decision in *Florence County School District Four v. Carter*, parents may make a unilateral placement in a non-state-approved school and receive tuition reimbursement, if they can show that the new school meets the goals of the Individualized Education Plan (IEP) and that equitable factors support the request for tuition reimbursement. In order to make such a unilateral placement, a parent must be able to pay the tuition until the resolution of the administrative appeals. For this reason, the Supreme Court decision has been characterized by some as "the rich man's decision." In this case, the family was poor and from a minority group with no ability to pay the tuition. With the urging of the WPLS attorney, the school granted a "scholarship" to the child pending the result of the hearings. Given the success of similar appeals regarding unilateral placement, it is anticipated that certain private schools will help assure equal access for poor children.



## Residential Placements for "Aged Out" Adults

For the past ten years, New York State has continued out-of-state residential funding for adults who had "aged out" of their educational or social services placement. The funding has been a match of state and local funds. The PADD legal support unit in New York City, New York Lawyers for the Public Interest (NYLPI), assisted in the prevention of a precipitous repatriation of adults with developmental disabilities back to New York State from these out-of-state residential school programs. At issue was the desire by the New York City officials to discontinue the city's 50 percent cost share of funding for these placements. Although the city makes these payments voluntarily and may opt out of this arrangement, the method of notifying parents was such that the parents were informed of no other alternative placements except the return to their own homes within two weeks. There was to be no orderly transition and the parents were in a state of panic. The NYLPI attorney began a series of telephone negotiations with the appropriate officials. In addition, a letter was sent to the New York City Council opining that "dropping off" adults in unsupervised situations or to homes ill-equipped to handle the problems of these adults, might pose a liability issue for the city. A compromise was reached between the city and the state, which bears the other 50 percent of the tuition cost, and the adults remain in their placements.

## Employment Protection

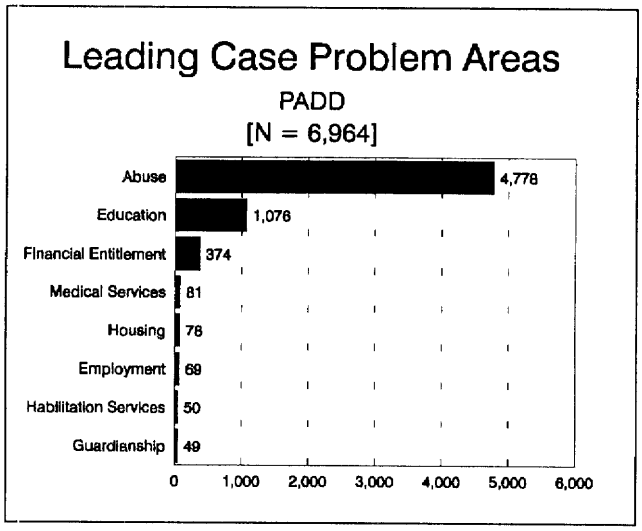
In another New York City case, NYLPI achieved significant results without employing litigation. At issue was a parent's concern that her son with mental retardation was hired by the New York City Board of Education without granting him the status of a person with a disability as had been promised. Instead, the young man was hired solely as a temporary employee without any protections. NYLPI assisted the mother in gaining the intervention of the Equal Employment Opportunity Commission (EEOC), which advocated for a settlement granting the young man permanent status but not as a person with a disability. The EEOC would go no further with regard to the disability status and, therefore, NYLPI assumed control of the case and entered into direct negotiations with the Board of Education. A new settlement was negotiated granting the permanent disability status; but, this time, the city failed to honor the new agreement. Finally, after intervention from NYLPI and a local congressman, the family prevailed and the young man is working as a permanent New York City employee with full protection.

## Medical Care and Equipment for a Needy Child

The PADD NYC office came to the aid of 8-year-old Adam who has mental retardation and physical challenges. He was a recent immigrant from Nigeria and neither of his parents spoke English. The local school district had managed to modify a wheelchair for Adam to ensure proper seating. However, one day while Adam's father was carrying Adam down several flights of steps from their apartment to the city street below, he watched in horror as the unattended wheelchair was crushed by a New York City sanitation truck. Since there was no receipt for the wheelchair, they could not process an insurance claim with the city. The family's medical insurance would not cover the bill and the family's income exceeded the Medicaid eligibility limit. The Commission's advocate assisted the family in contacting the Rusk Rehabilitation Institute and the Physically Handicapped Children's Program. Rusk admitted Adam for rehabilitation and corrective surgery. With the hospitalization, Adam became eligible for Medicaid under the *Katie Beckett* waiver. Medicaid eligibility assured continued care and equipment for this very needy child and his family.

## Support for Combination Program

Often in pre-school education, parents are asked to access their own private insurance to cover some related expenses.



There is no obligation to do so but some families are agreeable and make the claims on their policies. The Commission's Long Island PADD office, Long Island Advocates Inc. (LIA), intervened on behalf of a family whose insurance company served notice that it would no longer pay for therapies for Kevin G., a youngster with encephalopathy and left paraplegia. When the family requested that the Committee on Pre-school Education (CPSE) pay for the in-home therapies, the Committee denied the request. The basis of the denial was the determination by the Nassau County Department of Mental Health not to pay its share of this combined center-based and in-home program. The LIA advocate showed successfully that the State Education Department and federal regulations did not prohibit such a combined program and that the county was exceeding its authority by vetoing such a plan. A new IEP was developed and Kevin is receiving his combination program.

## Developmentally Disabled Parent

Every year the PADD program is faced with the issue of mothers with developmental disabilities losing custody of their children on the presumption that developmental disabilities indicate a deficiency in nurturing. Once again, the Commission's northern and most rural office, North Country Legal Services (NCLS), was asked to intervene on behalf of a mother with developmental disabilities. The mother, Sally, was a high school student with mental retardation who continued to live at home with her parents and the new infant. Sally transferred legal custody of her daughter to her parents and she assisted with the infant's care. One day Sally mentioned to one of her school teachers that she had hit her child. The teacher reported the incident to the Child Protective Services (CPS) and the caseworker removed the infant to an emergency foster home. The Child Protective worker refused to allow the baby to return to the grandparents unless Sally was permanently removed from the home. With NCLS's help, it was determined that the witness who reported the incident had agreed with the permanent separation of mother and daughter because she felt that there were no support services available for the mother. When a systematic plan of support was arranged for the entire extended family, the CPS agreed to cooperate and the family court action was adjourned in contemplation of dismissal. The family has remained together as an intact unit.

## Reasonable Accommodation and Access

With the advent of the Americans with Disabilities Act (ADA) there has been considerable debate and some case law over the responsibility of landlords to provide reasonable accommodation for tenants. What has been clear is that the cost of such accommodation, as long as it is not an undue hardship, is to be borne by the landlord. In a case which came to the Commission's PADD office in the Southern Tier, Broome Legal Assistance Corporation (BLAC), the tenant installed a wheelchair ramp at her own expense for her paraplegic son. When the landlord threatened to tear down the ramp, the BLAC attorney corresponded with the landlord alerting her to the ADA and indicating that as long as the ramp was properly installed and not a hazard, it could not be removed. This information was sufficient for the landlord and guaranteed continued access for the individual.

## Least Restrictive Environment

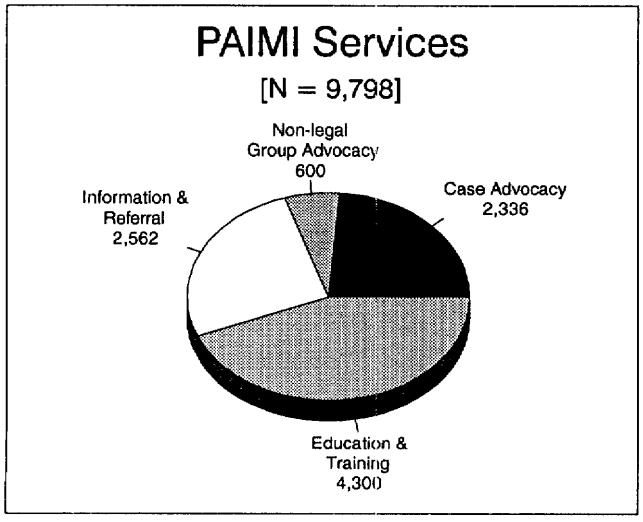
The Rochester PADD office, Western New York Advocacy for the Developmentally Disabled, combined resources with the Buffalo office, Neighborhood Legal Services, to file a complaint with the U.S. Department of Education, Office of Civil Rights. In New York State, neighboring school districts form Boards of Cooperative Education Services (BOCES) for the purposes of affording space for special education services. The BOCES may rent space from one of the individual districts or, as is the case in many parts of the state, the BOCES build separate buildings to house the special education programs. The complaint asserted, among other things, that the rights of students to placement in the least restrictive environment would be violated by placement in a to-be-constructed BOCES facility expansion that was separate and distant from the home school district's. This past spring, the Office of Civil Rights and the State Education Department entered into an agreement on the matter. The State Education Department agreed to monitor individual school district placements to ensure that placement in this BOCES program is the least restrictive environment.

# Protection and Advocacy for Individuals with Mental Illness

The Commission continues to administer the federal Protection and Advocacy for Individuals with Mental Illness program, established by Congress to protect individuals with mental illness from abuse and neglect and to advocate for their individual rights. The PAIMI program also operates via a statewide network of regional offices set up to provide an array of legal and non-legal services. During the past year, the program served over 9,000 individuals, including 2,336 individuals through case advocacy, 600 persons in non-legal group advocacy services, 2,562 individuals with information and referral services, and 4,300 individuals in education and training activities. Examples of cases are listed below.

## Discharge from Supported Apartment Prevented

New York Lawyers for the Public Interest, Inc. successfully prevented the imminent discharge of an individual with a psychiatric disability from his supported apartment program. The provider initially sought to discharge him without proper discharge planning, and without an eviction proceeding in court. After NYLPI's intervention, an agreement with the residence to provide extensive assistance to the individual to locate alternative housing was negotiated. As a result, he found alternative housing and has moved on his own accord.




## Employment Restored

The Touro College PAIMI program successfully negotiated with the counsel for the Metropolitan Museum of Art in New York City to have the position of an employee who is mentally ill restored to him. The employee had been terminated from his job by the museum after he experienced an episode of manic depression while at work. After commencing an Equal Economic Opportunity Commission action, but prior to filing a lawsuit, the individual was restored to his position at the museum and paid several thousand dollars in back pay for lost time. He was also elevated to a higher salary level, with full benefits.

## Deaf Client Assisted

Neighborhood Legal Services, Inc. filed a complaint with the Department of Health and Human Services Office of Civil Rights on behalf of a deaf client who alleged he was denied access to interpreters for his mental health treatment at an acute care psychiatric ward of a general hospital. The complaint was accepted for investigation by OCR and NLS staff provided input regarding the development of an interpreter policy for the facility in question.

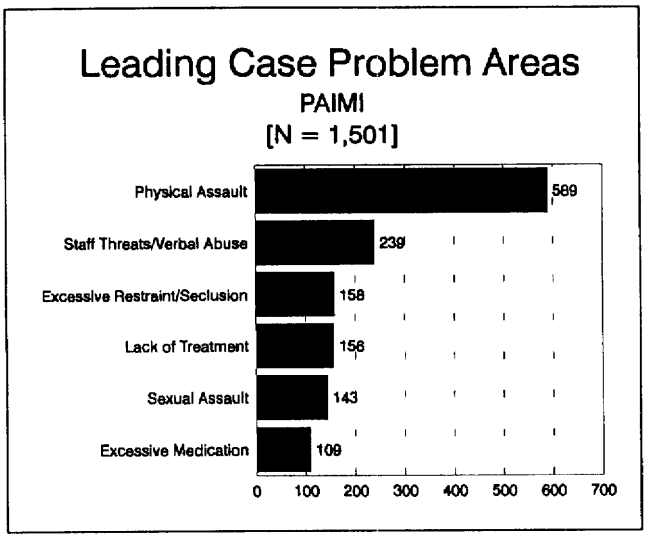
## *Pro Se* Assistance Provided

Legal Services of Central New York, Inc. assisted an individual whose husband had separated from her while she was an inpatient in a psychiatric center. The husband then obtained an attorney and served her with divorce papers. Although PAIMI could not represent this individual in a divorce action, they provided her with assistance in the form of drafting a *pro se* answer and counterclaim and also assisted her in the timely serving and filing of it. She then had the additional time she needed to seek a private attorney to represent her in the divorce action.

## Appropriate Treatment Sought

North Country Legal Services, Inc. assisted a patient at St. Lawrence Psychiatric Center who had been hospitalized for most of the past eight years with a diagnosis of pedophilia. The client, who had originally been a voluntary admission and who appeared to want treatment, was receiving only very basic "maintenance" at the psychiatric center because staff felt they had no expertise in treating the problem and had sought no other avenues of accessing treatment for him.

After NCLS wrote to the Commissioner of Mental Health requesting that the client be provided with effective treatment for his problem, OMH moved fairly quickly to identify




a sexual disorders program at New York Psychiatric Institute and the client was transferred into that program. NCLS remains involved with this case, since the individual has completed his course of treatment at NYPI and has returned to St. Lawrence PC, planning to obtain community treatment in the near future.

## Sexual Assault Victim Assisted

Disability Advocates, Inc. assisted a patient in a psychiatric center who alleged that she had been sexually assaulted by a male patient, restrained unnecessarily on three occasions, and that she was receiving no treatment.

As a result of PAIMI staff involvement, she was transferred to another unit that evening. DAI persuaded the psychiatric center to curtail its use of restraint and a detailed treatment plan was devised by her treatment team. The psychiatric center conceded that the patient had not been properly prepared for a previous transfer to a new unit, leading to one of the incidents of restraint. The charge nurse is now required to introduce herself to patients upon their arrival at a new unit.

# Client Assistance Program

The Commission's statewide network of dedicated Client Assistance Program (CAP) offices and advocates work to assist New Yorkers with disabilities in accessing an array of state-administered vocational rehabilitation and related services. New Yorkers with disabilities continue to represent one of the state's most unemployed and underemployed segments of its citizenry. CAP services are a critical link to individualized vocational services for many individuals who would otherwise find navigating the service delivery system frustrating and intimidating.

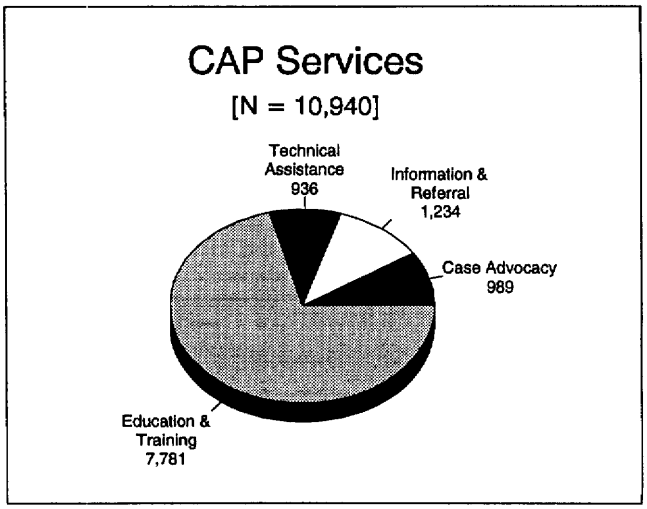
In the reporting year, over 10,000 persons with disabilities were served by CAP. Nearly 1,000 New Yorkers received intensive advocacy case services. CAP advocates demonstrated their broad knowledge base of vocational and related services also in providing information and referral to over 1,800 individuals and technical assistance in over 900 cases. Individuals trained on their rights and responsibilities in the state's vocational rehabilitation and related services systems exceeded 7,000.

As mediators, advocates and legal representatives, CAP professionals assume roles that ensure access to effective rehabilitation and related services. The cases profiled below illustrate a range of issues CAP advocates confront on a daily basis.

Consumer complaints vary, ranging from individuals seeking sheltered employment services to individuals seeking sponsorship for professional graduate studies.

## Transportation

Mr. A was engaged in college training and requested assistance from CAP when a Commission for the Blind and Visually Handicapped (CBVH) delay in processing his grant award caused him financial hardship. Mr. A lived on a fixed income. As a result of a CBVH delay in processing Mr. A's college grant award he incurred substantial transportation expenses. The Capital District Center for Independence (CDCI) CAP office intervened to negotiate interim CBVH support for his ongoing transportation expenses. As part of the negotiated settlement, CBVH reimbursed Mr. A for out-of-pocket transportation expenses when his college award was finalized. In resolving this financial hardship, Mr. A was able to successfully proceed with his college pursuits.



## Transition School to Work

Mr. D was a high school student who approached the Long Island Advocacy Center (LIAC) CAP office for assistance with coordination of his transition plan. Mr. D and his mother were under the impression that the VESID counselor was responsible for setting up a work/study maintenance program in conjunction with the high school. VESID apparently had not played a role in coordinating the program and was not even aware that Mr. D was attending daily. The school had arranged for Mr. D's participation in an Office of Mental Retardation and Developmental Disabilities (OMRDD)-sponsored employment training program and was providing transportation. Mr. D was informed that he would be paid for his work/study and was required to sign time sheets on a daily basis. As a result of a breakdown in communication, however Mr. D was not being paid.

LIAC intervened to negotiate a resolution between OMRDD and Mr. D which resulted in full payment for his work study. CAP then facilitated VESID's involvement in planning and implementation of Mr. D's transitional program. LIAC also alerted Mr. D and his parents to a host of specific transition requirements the school is obligated to undertake, including Mr. D's full participation in any and all planning.

## Transition from Sheltered to Supported Employment

Ms. E was a VESID consumer who participated in a sheltered workshop for over three years despite her long-standing interest in exploring employment prospects outside the workshop. A family member contacted LIAC, frustrated because the sheltered workshop setting underestimated Ms. E's potential and did not encourage work activity consistent with her abilities. LIAC's intervention led to Ms. E's transition from sheltered to supported employment where she is currently employed in document preparation in an integrated office environment.

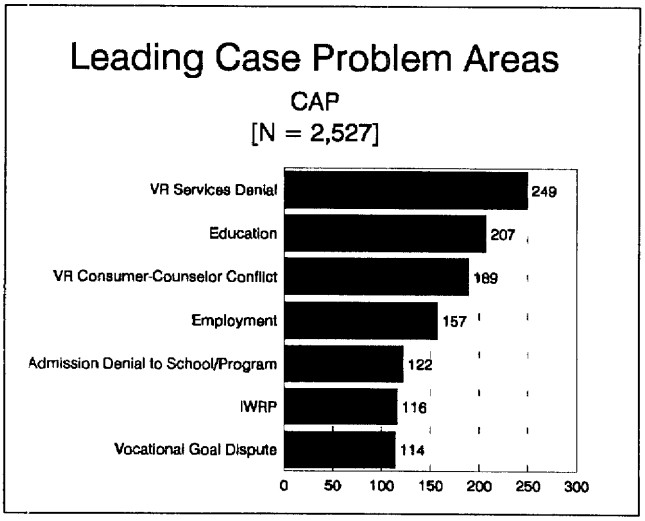
In another LIAC transition employment case, Ms. F was not satisfied with sheltered employment at the local Association for Retarded Citizens facility where she had worked for 15 years. Her case manager and staff at her group home contacted LIAC and were interested in exploring supported employment. Ms. F is a high functioning, developmentally disabled person with a speech impairment. Despite her limitations, the group home staff were confident Ms. F was ready to work in the community.

CAP assisted in convening a meeting with VESID to discuss service options. Ms. F's counselor had denied supported employment services based on concern about Ms. F's problem behaviors, which he believed would inhibit her work performance. The group home staff disagreed with that assessment and explained how they had successfully worked with Ms. F to limit inappropriate behavior at the group home. Group home staff also indicated that the sheltered employment program had repeatedly refused to incorporate a behavior modification program into Ms. F's work environment. CAP negotiated a plan of action with the sheltered employment program that incorporated a commitment to supported employment as an eventual outcome for Ms. F. Toward this goal, Ms. F's work environment was restructured and a behavior modification plan was implemented.

## Sponsorship for Law School

Mr. G was a VESID consumer with an emotional disability who was denied VESID sponsorship for law school. He had successfully completed a paralegal course and was encouraged by his instructors to go on to become a lawyer. VESID questioned Mr. G's ability to handle the stress associated with law school and the legal profession in light of his disability. Mr. G and CAP countered VESID's objections by requesting a re-evaluation that ultimately determined a career in the legal profession was consistent with Mr. G's abilities.

Mr. G applied to law school and, with an acceptance letter in hand, he continued to lobby for VESID sponsorship. As part of the negotiations with VESID, LIAC referenced *Chirico v. VESID* and *Polkabla v. CBVH,* in which the courts have held that the Rehabilitation Act is "designed to meet the broad range of needs of individuals with handicaps in becoming integrated into the competitive workplace and the community... and in reaching their highest level of achievement." Mr. G is presently attending law school with VESID sponsorship.



## Eligibility

Mr. H was a VESID consumer in recovery from alcohol and substance abuse. His VESID counselor requested that he participate in an evaluation to assess his commitment to recovery. Failure to participate in the evaluation would have prompted VESID to close his case. Mr. H was working in a seasonal food service position which did not allow him to participate in the VESID evaluation. When Mr. H explained the reason for his unavailability, VESID interpreted it as a lack of commitment to his rehabilitation.

The Center for Independence of the Disabled in New York (CIDNY) CAP office served to foster communication between Mr. H and his counselor and to validate the reason for his inability to participate in the evaluation. CIDNY stressed that Mr. H's summer employment was his only means of financial support and that he would be willing to participate in an evaluation in the fall. The counselor agreed to keep the case open and arranged for an evaluation at the conclusion of the summer season.

## Employer Technical Assistance

Mr. X was a VESID consumer with a learning disability who successfully secured employment with a major corporation in the central New York area. The corporation's personnel director contacted VESID for assistance and information with regard to diagnostic testing and job analysis to accommodate Mr. X's learning disability. Essentially, the personnel manager was informed that under the Americans with Disabilities Act (ADA), the employer was responsible and that it was not VESID's problem. The CAP advocate met with the district office manager to discuss the case noting that, technically, the employer is responsible for accommodations, but that VESID has a legitimate responsibility to assist employers in this effort.

The VESID district office manager agreed to a meeting among the Rochester Center for Independent Living (RCIL-R) CAP office, a representative from the local learning disability association, and the employer in an attempt to minimize the fallout from this poorly-handled situation. Following the meeting, the district office manager contacted CAP and indicated that he was embarrassed by his staff's performance and would reopen Mr. X's case. VESID ultimately assisted with a neuropsychological examination and provided job coaching and other supports.

## Default Student Loan and College Sponsorship

Mr. Z was a VESID consumer recovering from chemical dependency and was denied college sponsorship. He also was in default on his student loan which threatened his future eligibility for TAP and PELL sponsorship. CAP attempted to mediate the dispute over college sponsorship by meeting with the VESID counselor who ultimately agreed that sponsorship for a bachelor's degree was supportable. Unfortunately, the senior counselor continued to object to college sponsorship and asserted that employment was possible in the field of counseling without a bachelor's degree. CAP met with the VESID district manager who ultimately agreed to the undergraduate sponsorship.

In an effort to address Mr. Z's defaulted student loan, CAP contacted the New York State Higher Education Services Corporation and negotiated a ten dollar per month repayment schedule. Mr. Z is currently attending college with VESID sponsorship and is no longer in default on his student loan.

# The PAIR Program

The Commission administers the federally funded Protection and Advocacy for Individual Rights Program (PAIR). This advocacy program, authorized by the Rehabilitation Act, provides authority and funds to states and territories to represent persons with disabilities who do not qualify for other existing advocacy programs. Typically persons with mental illness living in the community, and persons with adult-onset disabilities are eligible for PAIR services.

This has been a significant growth year for the Commission's PAIR Program. With the increased availability of federal funds for the program, the Commission was able to add three new regional offices in the state's Long Island, Capital District, and Central New York regions to complement the existing PAIR offices in the New York City and Buffalo regions.

After a competitive request for proposal process, the Commission selected the following agencies to serve as new regional PAIR offices:

- Nassau/Suffolk Law Services Committee, Inc. located in Islandia, NY (Long Island)
- Legal Services of Central New York, Inc. located in Syracuse, NY (Central)
- Disability Advocates, Inc., located in Albany, NY (Capital District)

During the past year the New York State PAIR program served over 1,000 persons with disabilities, their families and advocates. Two hundred and thirty persons were provided with legal representation or intensive case advocacy services. Another 57 persons were given technical assistance in pursuing their rights while 232 persons were provided with information or appropriate referral. Lastly, 480 additional persons were trained at 25 educational sessions.

The following are examples of the legal and advocacy cases handled by PAIR staff during the past year.

## HIV/AIDS Case

New York Lawyers for the Public Interest, in the most-widely reported PAIR case in the nation, obtained a favorable settlement in the *Mason Tenders District Council Welfare Fund vs. Donaghey* lawsuit. Judge Sprizzo, Judge of the Federal District Court for the Southern District of New York, approved the final settlement in August, 1995 granting a client and the estate of a deceased client damages for emotional distress. The judge's order also required the insurer to change its policy coverage which arbitrarily excluded the cost of coverage for expenses related to HIV or AIDS, so it no longer unfairly discriminates against persons with these diagnoses. This lawsuit deservedly received national attention and has been cited in a host of similar lawsuits throughout the nation.

## ADA Reasonable Accommodation

Disability Advocates, Inc. (DAI) negotiated a settlement of an EEOC complaint against an employer by an 80-year-old employee with terminal prostate cancer. Radiation and chemotherapy reduced his bladder functioning by 50%, requiring him to have immediate access to a bathroom facility when needed.

The employer closed the bathroom used by the employee and instructed him to use a facility in another part of the building. The employee was also instructed not to leave his desk until a security guard replaced him. No valid security reasons for this requirement were found.

The employee suffered extreme pain while waiting for his backup to arrive. He frequently urinated in a jar because he could not wait for backup. Because of the daily humiliation, the employee stopped drinking liquids, endangering his health. The employer refused to provide him with the reasonable accommodation of a nearby bathroom.

After four years of battling with the employer, the employee filed an EEOC complaint. The EEOC investigator sided with the employer, telling the employee he was unreasonable. The employee then contacted DAI. DAI notified the employer that it was ready to file a lawsuit in Federal Court seeking injunctive relief and damages. The employer agreed to settle the complaint. The employee now has a key and unlimited access to the nearest bathroom.

## Timely Access to Benefits

Nassau/Suffolk Law Services has been successful in negotiating an effective SSI pre-release application process for persons with mental illness being released from the Kings Park Psychiatric Center. This process has resulted in individuals receiving SSI benefits within a few weeks of discharge as opposed to six months or longer delays which were common previously. N/SLS hopes to expand this successful process to other psychiatric centers in their region.

## A Challenge to Limited Benefit Coverage for Mental Illness

In a lawsuit, *Leonard F vs. Israel Discount Bank of New York*, filed in federal district court, NYLPI is challenging a two-year coverage limit in a bank's long-term disability insurance. The plan covers all other disabilities up until the age 65, if the person remains disabled, except for those disabilities caused by "mental, psychoneurotic and personality disorders." Limits of this kind are common in long-term disability plans.

Leonard F, the plaintiff in the action, has a psychiatric disability. His long-term disability benefits were due to expire as a result of this two-year limitation clause when the lawsuit was filed. NYLPI argues that this policy violates the Americans with Disability Act because the policy covers other disabilities until the individual turns 65 years old. Title I of the ADA prohibits discrimination in all terms and conditions of employment including fringe benefits.

*Litigation is a tool of last resort when other means of problem resolution have proven unsatisfactory. However, it has been used effectively in actions resulting in the protection and enforcement of rights for persons with disabilities.*

## Another Challenge to Disability Discrimination in the Provision of Insurance

As a result of NYLPI developing a national reputation in the area of disability and insurance coverage, they were asked to submit an *amicus* brief on behalf of several national organizations in a discrimination case, *Gonzales v. Garner Food Services,* on appeal in the Eleventh Circuit. The National Association of Protection and Advocacy Systems, the Association for Retarded Citizens, the National Alliance for the Mentally Ill, and the National Association of People with AIDS were among the interested parties.

At issue in the appeal is a lower court ruling which found that the person with AIDS, who was the plaintiff in the suit, was not covered because the Americans with Disabilities Act (ADA) did not cover former employees, and, moreover, the ADA was not in effect when the defendants took their actions. These actions included the firing of the plaintiff and a subsequent limitation on AIDS treatment coverage under the employer's COBRA health plan (a health plan required of employers for former employees).

The NYLPI's *amicus* brief argued that the lower court's ruling was inconsistent with the purpose of COBRA and that the employment provisions of the ADA apply to anyone qualified for a position and eligible to receive benefits.

# Legal Interventions

Federal statute provides the power to use legal interventions to protect and enforce constitutional rights. Litigation is a tool of last resort when other means of problem resolution have proven unsatisfactory. However, it has been used effectively in actions resulting in the protection and enforcement of rights for persons with disabilities. The following are examples of legal actions pursued by the advocacy programs during the past year.

## PADD Legal Actions

### Medicaid Reinstated For Disabled Adult Child (DAC) Recipients

*McMahon v. New York State Department of Social Services*

The Commission's Western New York PADD legal support unit, Neighborhood Legal Services, reached a final settlement in *McMahon v. New York State Department of Social Services.* At issue was the fact that individuals whose status was changed from Supplemental Security Income (SSI) to Social Security Disabled Adult Child's benefits by virtue of a parent's death or retirement were being automatically terminated from Medicaid benefits. Under the *Pickle* amendment to the Social Security Act, any beneficiary receiving such a change was to have a special computer code indicating that Medicaid benefits were to be retained. Due to an alleged "glitch" in the system, approximately 4,000 New York State residents lost their Medicaid coverage. The settlement called for notification to all 4,000 "class" members that they should complete an attached form for a reconsideration of their case. If there is an adverse decision made regarding the case, the individual will retain the usual Social Security appeal rights. A public information campaign began to notify individuals about the letters and to stress the importance of responding to the notices within thirty days.

### Special Education Services To Be Provided In A Parochial School

*Colleen Russman v. Board of Education of the Enlarged School District of the City of Watervliet*

The Commission's PADD program for the Capital District, the Albany Law School Disabilities Law Clinic, won a significant federal court reversal of a federal magistrate judge's decision which prohibited the placement of a consultant teacher and teaching aide at a parochial school. At issue in *Colleen Russman v. Board of Education of the Enlarged School District of the City of Watervliet* was the desire by Colleen's parents to educate this special education student at the St. Brigid's School using the services of a consultant teacher and aide as prescribed by Colleen's Individualized Education Plan (IEP). Magistrate Judge Smith had ruled that such an arrangement of using publicly-funded staff at a parochial school was in violation of the Establishment Clause of the First Amendment to the U.S. Constitution.

In his reversal of Magistrate Smith's decision, Judge Con Cholakis of the U.S. District Court for the Northern District ruled that "the services set forth in Colleen's IEP are to be provided through a general program that is in no way skewed towards religion [and] under which no funds traceable to the government find their way into sectarian schools coffers." In further applying standards set forth in the US Supreme Court's *Zobrest* decision, Judge Cholakis stated that the use of a consultant teacher and teaching aide did not add to the religious environment of the school. This decision clarifies a very controversial issue which had affected parental freedom of choice in educating their special education offspring.

### Home And Community-Based Waiver (HCBS) Appeal

*Matter of Kevin Caffrey*
*Caffrey v. Wing*

The Albany Law School (ALS) Disabilities Law Clinic also submitted in this report period the first recorded appeal under the State Office of Mental Retardation and Developmental Disabilities (OMRDD) Home and Community-Based Waiver (the Waiver) program. Under the Waiver program Medicaid can be used to purchase a variety of services for individuals with mental retardation/developmental disabilities which normally would not be Medicaid-reimbursable. In the *Matter of Kevin Caffrey,* Residential Opportunities Inc. (ROI), a private non-profit agency, was providing Medicaid-funded residential habilitation services in Kevin's home. ROI decided to terminate those services because it claimed that Kevin's parents were uncooperative. However, the ROI decision was not followed with a notice or declaration of the parent's right of appeal. Fortunately, the parents went to ALS and Joseph Connors Esq. made an appeal under Title XIV Part 633 of the New York State Code of Rules and Regulations.

The OMRDD Hearing Officer ruled that, as an agent of OMRDD under the Waiver, ROI had not acted appropriately when it abruptly discontinued services to Kevin because it considered the family hostile and difficult. Rather, the agency should have advised the family 30 days in advance of the termination of services and that the family had a right to appeal the termination of services. ROI was ordered to provide residential habilitation services to Kevin Caffrey as outlined in his August 1993 Independent Service Plan (ISP). The decision is significant because, to date, the OMRDD had claimed that the Waiver Program was not an entitlement and thus carried with it no due process rights. The ALS argued that the waiver is still under Federal Medicaid law despite its characterization as a waiver.

### Woman Remains In Her Own Home After Conflict with Public Agency

*Article 81 Guardianship*

Mary had been living in a boarding house with her mother for many years in the community of Cooperstown, New York. When Mary's mother passed away, the Protective Services for Adults in the county made a decision based on the caseworker's opinion that Mary, who has a developmental disability, did not have the capacity to decide to continue living in the boarding house and, further, that she lacked sufficient skills in independent living. The county began an Article 81 Guardianship proceeding to appoint a guardian to remove Mary from the boarding home. The county alleged that the home was not licensed as a provider and that Mary would be better served in a group home. Mary's friends and the immediate community protested what they characterized as unnecessary government intrusion into an individual's private life, solely because she had a developmental disability. A local newspaper wrote a story and the PADD office in Binghamton was contacted for assistance.

Although it is the policy of the PADD program not to handle guardianship petitions or to become a guardian for individuals, PADD offices have assisted individuals with developmental disabilities in challenging guardianship petitions. In this instance, the PADD attorney from the Broome Legal Assistance Corporation had a clear indication from Mary that she wanted to remain in this boarding house which she considered home.

The PADD attorney was successful in convincing the Supreme Court Justice to permit Mary to remain as her own guardian with the provision that the local ARC provide supervision and training to Mary on money management and other independent life skills. The local Adult Protective Services closed its case and Mary remained fully integrated within her community.

## PAIMI Legal Actions

### Access to Records Procedures Clarified

North Country Legal Services, Inc. assisted a client in at St. Lawrence Psychiatric Center in gaining access to his medical records, and in the process assisted the NYS Office of Mental Health in clarifying the procedures for records access.

The client had attempted to access his records at the psychiatric center and been denied. In the past, appeals to decisions such as these were handled through a series of regional Office of Mental Health offices around the state, but during the past year these offices were closed due to cost-

cutting measures. The facility director did not know the current appeals process, and neither did the Counsel's office at the Office of Mental Health.

The PAIMI attorney filed an Article 78 petition challenging the denial of access and lack of due process. Within a week, their client was given access to his medical records. A month later, an acceptable settlement was agreed upon which should resolve questions about access and due process throughout the state. The Office of Mental Health agreed to revise its policy to include two important points:

1. Patients denied access to records will receive a due process notice specifying appeal rights and time frames.
2. Individuals granted access will be presumed to have meaningful access, i.e. facility directors will have to make reasonable arrangements to have illegible entries made legible.

### Inappropriate Nursing Home Discharge Challenged

Disability Advocates is representing an individual with a mental illness who was summarily discharged by a nursing home to a hospital emergency room. The nursing home refused to let their patient return because of his alleged unmanageable behaviors. The individual had not been provided with mandated necessary services that would have enabled him to live safely in the nursing home.

The PAIMI attorney defended the client in a special proceeding brought by the hospital to transfer him to an out-of-state facility against the wishes of both the client and his family. A federal court action will also be filed to compel the nursing home to permit the individual to return to the nursing home with services necessary for him to live there safely.

### Medicaid Coverage for Clozapine

New York Lawyers for the Public Interest, Inc. continued to be involved with cases of individuals with severe psychiatric disabilities who are in need of Clozapine. This past year, two such cases were significant.

In the *Matter of Ruth X v. Wing and DeBuono*, a 14-year-old who had done well on Clozapine as an inpatient was denied Medicaid prior approval for the drug on an outpatient basis because the FDA labeling for the drug does not cover persons under age 16. As a result of the denial of prior approval, the client decompensated and had to remain in the hospital at a much greater expense to the state. After receiving an unfavorable decision at a fair hearing, NYLPI filed a lawsuit on the client's behalf.

In the *Matter of Desiree L.*, NYLPI represented a person with bipolar disorder who has also been denied Medicaid approval for Clozapine because this use of the drug is "off-label." A fair hearing was held, at which NYLPI represented the client, and a decision is expected shortly.

### Mental Illness As the Basis for Denial of Admission to Adult Home

Neighborhood Legal Services, Inc. represented an individual who was denied admission to an adult home on the basis of mental illness. A lawsuit, *P.P. v. Connelly*, was filed in federal district court alleging violation of the plaintiff's rights under Title VII of the Civil Rights Act as amended by the Fair Housing Act, the ADA, Section 504 of the Rehabilitation Act, and the New York State Human Rights Law.

As a result of several telephone status conferences, the court has ordered a dismissal with prejudice. Because the order does not go far enough to protect the client's rights, the PAIMI attorney has filed a motion to vacate the current order and instate the plaintiff's proposed stipulation of settlement.

## CAP Legal Actions

### Advancing in Employment
*Chirico v. VESID*

The case of *Chirico v. VESID* focused on the critical question of eligibility for individuals attempting to advance in employment. The NYS Appellate Division's decision ruled that "the Rehabilitation Act is clear in that services must be provided consistent with an individual's abilities."

Mr. Chirico is a high school guidance counselor who is quadriplegic and has limited use of his arms and hands. Disability Advocates, Inc., serving *pro bono* as the Capital Region's CAP legal support program, filed the Article 78 appeal based on Chirico's demonstrated need for voice-activated computer technology. The claim was based on clear references in the Rehabilitation Act, which calls for services to be available in order for an individual to retain and advance in employment.

A fair hearing decision directed VESID to purchase the voice-activated assistive technology. The VESID Deputy Commissioner reversed the decision, arguing in part that the system was not needed by Chirico to perform his current job duties. The NYS Appellate Court Decision in overturning the Deputy Commissioner's decision adds to an expanding body of legal precedent that calls for services provided under the Rehabilitation Act to be consistent with an individual's interests and abilities and to support the pursuit of meaningful careers.

### Home Modifications
*Bridger v. Gloeckler*

Legal Aid Society of Mid-New York filed an Article 78 complaint in State Supreme Court in the case of *Bridger v. Gloeckler*. Ms. Bridger is an eligible VESID consumer who is quadriplegic as a result of a spinal cord injury and was receiving VESID-sponsored home modifications services to pursue her vocational goal as a clerk typist/secretary.

The VESID-sponsored home modifications were not constructed in full compliance with American National Standards Institute's (ANSI) standards and represented a safety hazard for Ms. Bridger. In addition to calling for construction changes to assure full compliance with ANSI standards, CAP argued for additional home modifications to meet Ms. Bridger's safety needs.

The *Bridger* case highlights one of several long-standing problems CAP has experienced with VESID policies and practices governing home modification services. The Supreme Court ruled in CAP's favor stating that "strict compliance" with ANSI requirements are required.

### Vehicle Modification Equipment
*Marshall v. Switzer and Gloeckler*

*Marshall v. Switzer, Gloeckler* challenged VESID's denial to assist Mr. Marshall in the purchase of prescribed equipment for his modified vehicles. VESID routinely purchases the equipment in dispute when they are purchased as aftermarket modifications to a vehicle (i.e., power windows, heavy duty electrical components, air conditioning, etc.). VESID policy, however, prohibits funding of these same features when they are installed by auto manufacturers.

Prior to addressing the merits of this claim, the *Marshall* case received national attention because of a more universal legal issue of an individual "right of action." Early on in the legal proceedings, in response to VESID's motion to dismiss, the lower court ruled that consumers of vocational rehabilitation services do not have an "individual" right to challenge a state agency in federal court under Section 1983 of federal civil rights law. This ruling was based on a child welfare case (*Artist M. v. Suter*) where the US Supreme Court ruled an individual right of action did not exist for recipients of child welfare services. The Court of Appeals rejected the application of the *Suter* standard to recipients of vocational rehabilitation services and affirmed "enforceable rights, privileges, or immunities within the meaning of Section 1983."

Upon the consideration of the merits of the vehicle modification issues, the District Court ruled that VESID was indeed required to fund factory-installed vehicle modifications and equipment.

# Education and Training

The work of the Commission's advocacy programs goes beyond individual case representation. A broad range of activities comprising trainings, technical assistance, outreach, and special projects provide assistance to countless individuals with disabilities, their family members, advocates, and others. In many instances, the change accomplished by these activities comes to fruition in a more timely fashion than protracted litigation. The following are examples of some of these activities.

- **Therapeutic Foster Care**: A new concept in caring for children with physical and mental disabilities is to place them with families who are paid an enhanced rate to provide a specialized foster care environment. The attorney at the PADD office at Broome Legal Services Corporation has been offering training on special education services to these therapeutic foster care providers. This training is targeted at assisting the families to access special education services and to be effective advocates for their foster care children.
- **Serving Children with Special Health Care Needs in School:** This specialized training was conducted by the Long Island PADD office, Long Island Advocates, Inc. More and more children with health care needs are returning to school from hospital settings and the training was meant to assist in this transition. The training focused particularly on the topic of health maintenance and safety of the chronically-ill child while at school.
- **Inclusion Training:** The Syracuse PADD office, Legal Services of Central New York, conducted several trainings on including children with disabilities into the mainstream school environment. The trainings assisted school personnel with ways to achieve successful inclusion. In addition, parents received training on ways of ensuring the supports necessary for a proper inclusion plan.
- ***Pro Se* Guardianship:** The NYC PADD office has been conducting *pro se* guardianship trainings for the past fourteen years. Families are trained in the petition process for an Article 17A guardianship in the Surrogate Court. The demand for this training has increased exponentially with more and more parents being faced with a need to be their own son/daughter's guardian to be fully accepted by providers when expressing that person's intentions. The training enables many parents to avoid the prohibitive costs of hiring an attorney.

- **Guardianship, Wills, and Estate Planning:** Although each PADD office fields questions and provides some training on future planning, it has been the Commission's central office which has worked with the Developmental Disabilities Planning Council on funding the writing and distribution of two manuals on guardianship, wills, and estate planning. One manual will be directed toward parents and will concentrate on the need to plan and tips on being an informed consumer when choosing an attorney. The second manual will be for attorneys and will concentrate on how to develop the appropriate future plan instruments.
- **Minority and Hispanic Outreach**: In addition to the Minority Outreach Coordinator position which was instituted eight years ago, the Commission's central office has hired a bilingual professional to assist with training and translation for individuals and families whose primary language is Spanish. It is a well known fact that the Hispanic/Latino population in New York State is ever-increasing and it is projected that in New York City, individuals of Hispanic descent will comprise 60-70% of the general population. Therefore, the addition to the Advocacy staff of a bilingual professional will assist the Commission in having a more responsive PADD program.
- **The Educational Advocacy Program**: This very successful training program continues into its fifth year with advanced training in Impartial Hearing presentation for parents who have completed the previous two sessions on special education regulations and Independent Education Plan (IEP) development. Another session has been introduced on transition planning for teenagers who are in the special education system and who will be entering the adult services arena at age twenty-one. All trainings are now conducted in Spanish by the new Commission Hispanic outreach professional.
- **Disabilities Awareness**: This other highly successful program continues presentations to school-age children about individuals with disabilities. Poster and essay contests follow, with the winners invited to Albany for a special award ceremony. This year disability awareness trainers have visited women's correctional facilities as a way to stress the importance of disability prevention. Many of the women in such facilities do not practice good prenatal care, and substance abuse during pregnancy is the leading cause of disability in children.
- **Parents with Disabilities:** Disability Advocates, Inc. was a co-sponsor of a conference entitled "A Meeting of the Minds," which brought together parents with psychiatric disabilities, social services personnel, mental health service providers, attorneys and advocates to discuss the termination of parental rights on the grounds of mental illness and other custody disputes where a party's mental illness is an issue. Two DAI attorneys and the PAIMI Director moderated workshops at this day-long event.

  Disability Advocates, Inc. has also made presentations regarding parents with psychiatric disabilities to the New York Association of Psychiatric Rehabilitation Services, Inc. conference and at a conference entitled "Baby Blues-Before and Beyond: Promoting Mental Health and Coping with Mental Illness Among Pregnant Women and Parents of Infants."
- **Fair Housing:** Disability Advocates, Inc. made presentations on the Fair Housing Amendments Act at the conference of the NYS Association of Community Residence Administrators and at a conference entitled "Housing for All."

  New York Lawyers for the Public Interest, Inc. presented at a conference on the Fair Housing Act as it relates to people with disabilities which was sponsored by the Association of Community Living, Rehabilitation Support Services, and other organizations.
- **Rights of Inpatients:** Disability Advocates, Inc. spoke about the rights of inpatients at two regional conferences sponsored by persons involved with mental health systems, "Taking Charge of Our Lives" in Saratoga County and the first Mid-Hudson Mental Health Conference in Poughkeepsie.

# Looking Ahead

## Private Psychiatric Hospitals

Despite their long-standing presence in New York State, private psychiatric hospitals have historically been a psychiatric treatment resource mostly to the high end of the mental health and addiction market. However, with the advent of managed care in the late 1980s significant changes have come about affecting their financing, the individuals they serve, and their services. Most significantly, these changes have brought the private psychiatric industry more into the sphere of the publicly-financed mental health system, and resulted in these hospitals providing services to more individuals with serious and persistent mental illness.

A Commission study to be released in 1996 examines the changing service role of this $172 million-a-year industry, its quality and cost of care, and the access and utilization of services particularly by individuals whose care is paid for by Medicaid and Medicare. It also evaluates the management practices and the relative competitiveness of these hospitals as the state considers greater reliance on them as an alternative to hospital stays in the shrinking state-operated psychiatric hospital system.

From its site visits to 8 of the 12 hospitals, the Commission's preliminary findings indicate that these hospitals offer a high quality of care to patients with commercial insurance and to the increasing number of children and elderly who rely on government sponsored insurance programs to finance their mental health care. When measured on a per diem basis, the private hospitals's $423 average Medicaid rate compares favorably to the state's free standing children's psychiatric centers cost of $600. Nevertheless, Medicaid patient stays were found to be longer than stays by comparable populations in general hospitals suggesting that there may be room for reductions in this area through the application of managed care techniques.

## Outpatient Psychiatric Clinics

Since the 1989 study entitled *Outpatient Mental Health Services,* where wide variances were noted in the actual unit cost of providing clinic services, much has been done by the state through the so-called COPs program to reduce the state's reliance on deficit funding while maximizing Medicaid revenue. Nevertheless, in a study of voluntary and county freestanding clinics that will be released in 1996, the Commission has found that little has been done to address the cost inefficiencies of clinic programs.

Using data obtained from Consolidated Fiscal Reports submitted by agencies to OMH, a survey sent to the agencies by the Commission, and site visits by fiscal staff to 11 agencies, the Commission examined five key factors affecting unit costs: reliance on salaried versus contract clinicians, clinician productivity, clinic hours of operation, no show rates, and the percentage of chronic mentally ill population served.

Preliminary findings suggest that providers using a predominately salaried work force have a substantially higher unit cost than contract clinicians and that the cost of providing clinic services is strongly affected by clinician output. Clinics that were open longer hours and had low show rates also tended to have lower unit costs. There seemed to be no strong correlation between the percentages of chronic clients served and unit costs. The study will recommend ways to improve the operational efficiency of these clinics.

# Appendices

# 1994-95 Publications

*Safeguarding Public Funds: A Review of Spending Practices in OMRDD Rate Appeals,* January 1995

*In the Matter of R.H.: A Patient at Manhattan Psychiatric Center,* April 1995

*Patient Safety and Services at Kingsboro Psychiatric Center,* July 1995

*In the Matter of Jacob Gordon: Facing the Challenge of Supporting Individuals with Serious Mental Illness in the Community,* August 1995

*Governance of Restraint & Seclusion Practices by NYS Law, Regulation, and Policy,* September 1995

## Brochures – *Could This Happen in Your Program?* Series:

*In the Matter of Noah Paul:* A Study in the Need for Improved Communication Concerning Individuals with Special Needs

*In The Matter of Frieda Fleischman:* A Study of the Interface Between Adult Homes and Mental Health Services

*In The Matter of Nancy Bauer:* Untrained Staff + Lack of Readiness = The Formula for Disaster

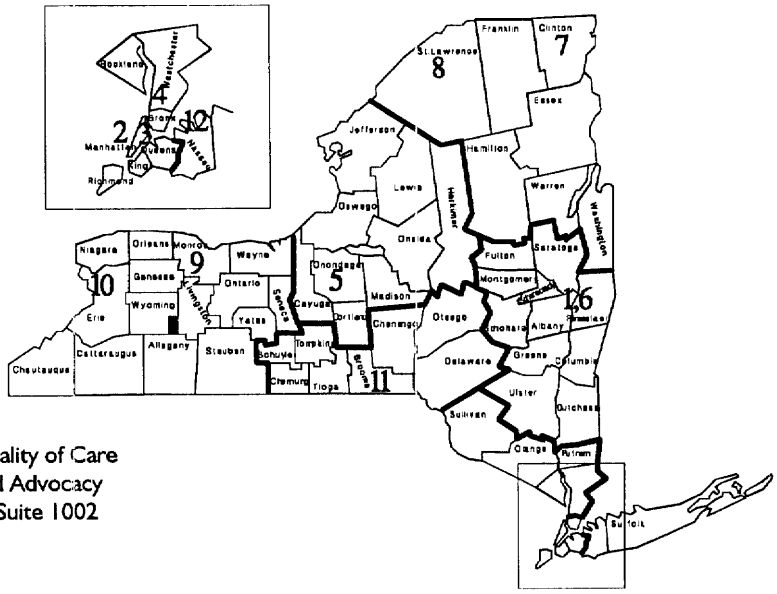
*In The Matter of Cynthia Ashley:* Death Follows Prescription Difficulties

*In The Matter of Rene Curtin:* Relaxed Vigilance Undercuts Standards of Care

*In The Matter of Bonnie Johnson:* Hot Water System with Malfunctioning Temperature Control Causes Life-Threatening Burns

In The Matter of Jesse Caron: *Lessons for Agency Administrators and Direct Care Staff on Abuse Cover-up*

# Protection and Advocacy for Developmentally Disabled Persons Regions and Offices

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3. New York Lawyers for the Public Interest, Inc.
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   (914) 949-1305

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5. Legal Services of Central New York, Inc.
   The Empire Building
   472 South Salina Street, Suite 300
   Syracuse, NY 13202
   (315) 475-3127

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6. Disabilities Law Clinic at Albany Law School
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   Albany, NY 12208
   (518) 445-2328

## North Country Region

7. North Country Legal Services, Inc.
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   Plattsburgh, NY 12901
   (518) 563-4022

8. North Country Legal Services, Inc.
   P.O. Box 648
   Canton, NY 13617
   (315) 386-4586

## Western Region

9. Western New York Advocacy for the Developmentally Disabled, Inc.
   Medical Arts Building
   277 Alexander Street, Suite 500
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   (716) 546-1700

10. Neighborhood Legal Services, Inc.
    495 Ellicott Square Building
    Buffalo, NY 14203
    (716) 847-0650

## Southern Tier Region

11. Legal Aid for Broome/Chenango Cos., Inc.
    30 Fayette Street
    P.O. Box 2011
    Binghamton, NY 13902
    (607) 723-7966

## Long Island Region

12. Long Island Advocates, Inc.
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    999 Herricks Road
    New Hyde Park, NY 11040
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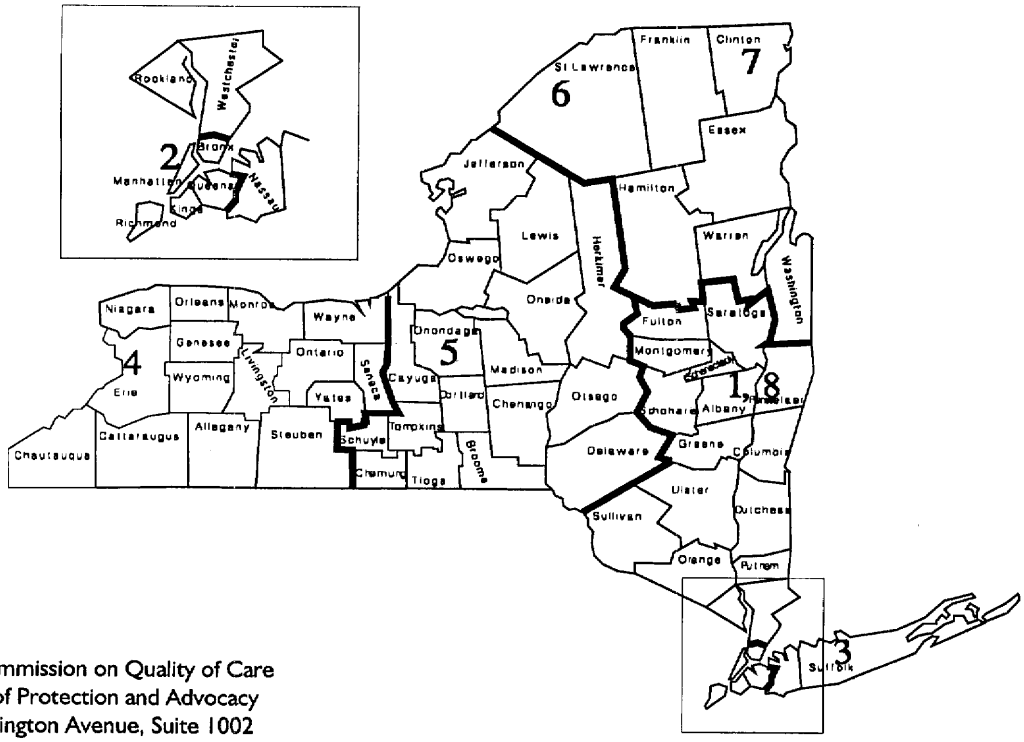
# Protection and Advocacy for Individuals with Mental Illness Regions and Offices

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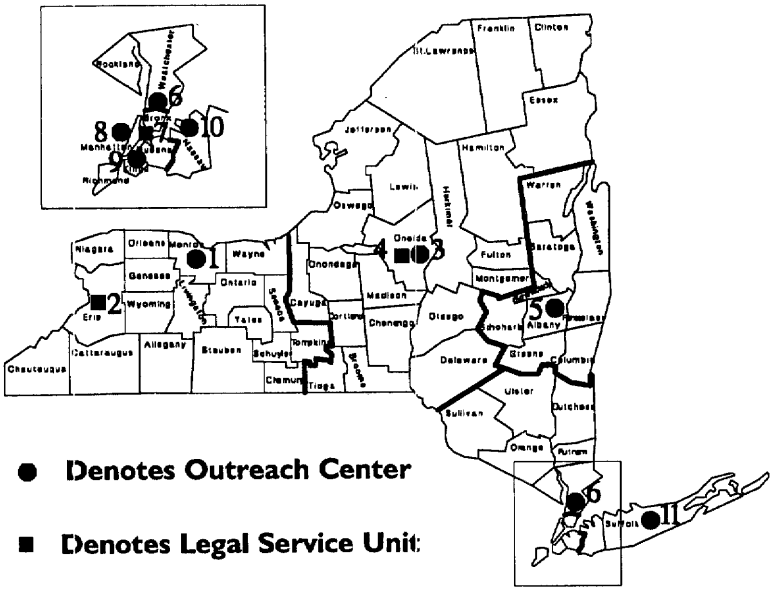
# Client Assistance Program
# Regions and Offices




● **Denotes Outreach Center**

■ **Denotes Legal Service Unit**

## Western New York Region

1. Rochester Center for Independent Living, Inc.
   758 South Avenue
   Rochester, NY 14620
   (716) 442-6470 (Voice and TTY)

2. Neighborhood Legal Services, Inc.
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## Central New York Region

3. Resource Center for Independent Living, Inc.
   409 Columbia Street
   Utica, NY 13502
   (315) 797-4642 (315) 797-5827 (TTY)

4. Legal Aid Society of Mid-York, Inc.
   255 Genesee Street
   Utica, NY 13501
   (315) 732-2131 (Voice and TTY)

## Hudson Valley Region

5. Capital District Center for Independence, Inc.
   845 Central Avenue, South #3
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6. Westchester Independent Living Center, Inc.
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*Publication Editor Marcus Gigliotti*

# State probe eyes security lapses in Kingsboro deaths

By AL GUART

Lapses in security and care played a role in the deaths of at least eight patients treated at Kingsboro Psychiatric Center, The Post has learned.

Three patients jumped to their death after they escaped or were issued passes, one was found dead in a hospital chair, and other deaths involved complications from treatment.

The findings were made by the state's Commission on Quality of Care for the Mentally Disabled, which has investigated a dozen of 70 deaths at the troubled Brooklyn facility since Jan[illegible]

## Parent workshops

**SARATOGA SPRINGS — Skidmore College will conduct workshops for parents of developmentally challenged children Tuesday and Thursday. Both events will be sponsored by the Partners in Growth Program of Skidmore's New Family Project; pre-registration is required.**

**An informal gathering for parents of children with special needs will be from 9:30 to 11 a.m. Tuesday in Emerson Auditorium of Palamountain Hall. Participants will discuss their mutual concerns and share ideas.**

**From 7 to 9 p.m. Thursday in Skidmore's Bolton Hall 281, Catharine McHugh, advocacy training coordinator of the New York State Commission on Quality Care, will present a worksho[illegible]**

# Hospitals Security Tightenin

## Psych-Centers Plan Announced by Pata[illegible]

New York Times

NEW YORK — After a spa[illegible] escapes, including one by a a r[illegible] tally ill man who pushed a wo[illegible] in front of a subway train weeks ago, Gov. George E. Pa[illegible] on Wednesday announced a pla[illegible] tighten security at psychiatric [illegible] pitals throughout the state.

The plan directs identifica[illegible] tags to be worn by everyone on [illegible] of the state's 29 me[illegible] assignment of staff m[illegible] cate missing patients, [illegible] of how patients are gr[illegible] ges to go into the com[illegible]

lan will without ques[illegible] e hospitals more se[illegible] s and for residents [illegible] e facilities," Pataki [illegible] l aggressively mor[illegible] ovements and take [illegible] s warranted," he s[illegible] J. Sundram, chair[illegible] s Commission on Q[illegible] hich monitors the n[illegible] ystem, said the [illegible] uch-needed meas[illegible] ccountability for [illegible] y and public safet[illegible] affe, a board mem[illegible] d Advocates for [illegible] said the answe[illegible] nts from escapin[illegible] rn from leaves is[illegible] hospitals more

# Adult home administrator indicted

*Nursing facility once owned by HAFTR, focus of federal investigation*

By Jeff Lipton

A former administrator of an adult home, which was owned by the Hebrew Academy of the Five Towns and Rockaway, was charged last week with defrauding a bank and embezzling benefits earmarked for residents of the home, officials said.

Beryl Zyskind, 43, of Brooklyn, was arrested on March 2, authorities said, for his actions as administrator of Hi-Li Manor Home for the Aged in Far Rockaway, which houses 120 residents, many of whom suffer mental disorders.

The indictment is the product of a two-year investigation launched in 1990 by the State Commission on Quality of Care for the Mentally Disabled, which uncovered "seriously deficient conditions" at the home. That probe also found that millions of dollars in public funds intended for residents of the home were diverted, officials said.

Mr. Zyskind and David Kolatch of Woodmere, a former executive director [illegible] at that time of the protection of vulnerable people," said Gary Masline, Quality of Care spokesman. "When individuals who have been entrusted with the responsibility to provide services to such people violate the public trust, exploit persons with mental disabilities and divert public funds from their care, they should be vigorously prosecuted."

He said Mr. Zyskind was the focus of the federal investigation and "I don't know what Mr. Kolatch's role was in the process."

But after the two-year investigation, state officials accused both of misusing funds, funnelling money from the mentally [illegible] personal


[illegible] administrator at HI-LI Manor Home for the Aged, where he's accused

# Fake Agency Misused Funds for Flushing Group Hom

By Meredith Stone

A state probe has found that the operators of a group home for 10 mentally retarded patients in Flushing diverted more than a half-million dollars in public funds and exposed residents to squalid living conditions from 1988 to 1992.

Abuses at the center included vermin-infested beds, a regular dinner of pork and beans and shoddy clothing for residents, according to a report issued by the state Commission on Quality of Care for the Mentally Disabled last week.

The operators of the home, Community Living Alternative, abruptly closed the facility and fled to North Carolina in November 1992 after the commission obtained a court subpoena to inspect its records, the report stated.

The commission criticized the home's monitoring agency, the state Office of Mental Retardation and Developmental Disabilities (OMRDD), for failing to detect the widespread neglect and misuse of funds at the home.

The report said OMRDD oversight was "neither integrated nor coordinated in any systematic way," stating that warning signs were constantly missed.

"The executive director and president of Community Living Alternative neglected and exploited the 10 residents of their facility," said Commission Chairman Clarence J. Sundram. "But the basic weakness in the OMRDD system of regulation allowed the deficiencies and fraud to exist unabated for years."

An OMRDD spokesman conceded that the Flushing facility, operated in an apartment building at 137-20 45th Ave., fell through the cracks. He said the agency is now reviewing its oversight procedure to make it better coordinated, which the commission recommended.

"It is clear to us there were some failures in our quality assurance mechanism," said Ron Byrne, an agency spokesperson. "But we want to stress that this is not at all typical of what these not-for-profit groups are doing. On a daily basis, heroic work is being done for the mentally retarded and their families."

The commission investigation revealed that the Community Living Alternative's executive director, Les Wright, was using a false name, Les White, and a fake s[illegible] security number to conceal his criminal record. The [illegible] also hid the fact that his wife, Kay, was the president o[illegible] center's "board of directors," the report stated.

Evidence concerning possible fraud, income-tax [illegible] lations and the filing of false records has been turned [illegible] to the Federal Bureau of Investigation and the [illegible] Attorney's office.

Over a two-year period, 153 checks were wr[illegible] payable to cash to cover costs in areas where the opera[illegible] were most deficient in providing for its residents, [illegible] commission found.

Among the allegations cited by the commission, C[illegible] munity Living Alternative deprived residents of f[illegible] fruits and vegetables for months, no attention was give[illegible] the special diets some patients required, air conditio[illegible] and the washer and dryer were broken and faucets [illegible] toilets leaked.

Also mentioned was intimidation and verbal abu[illegible] residents by staff and threats of evicting residents w[illegible] family members complained.