Falling Through the Safety Net:
"Community Living" in Adult Homes for Patients Discharged from Psychiatric Hospitals

New York State Commission on Quality of Care
for the Mentally Disabled

August 1993

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State of New York
COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Preface

Over the past several years, partly in response to budgetary pressures, the State Office of Mental Health has accelerated the decline of the census of state psychiatric centers. Whereas a decade ago nearly 22,000 patients resided in psychiatric centers, today there are fewer than 11,000; more than 60% of this census rundown has occurred within the past five years. Indeed, the rate of census decline since 1989 has been substantially greater than during the era of deinstitutionalization (Figures 1 and 2).

In the process of these census rundowns, many long-term patients are being discharged from psychiatric centers where they have spent substantial parts of their lives. This report presents case studies of two such long-term psychiatric center inpatients, Nicholas Cooper and Serina Williams,[1] whose discharges to adult homes ended in tragedies.

Figure 1: Patient Census Change in State Psychiatric Centers (1955-1992)

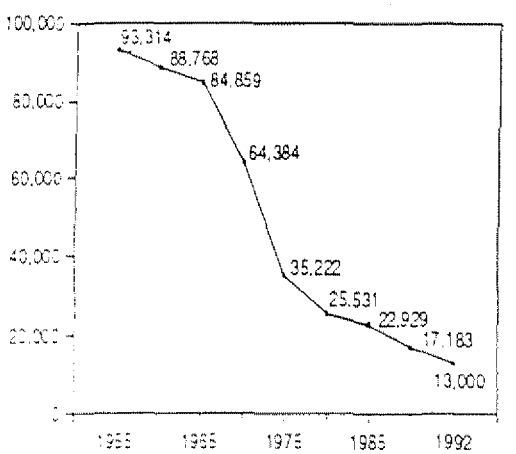
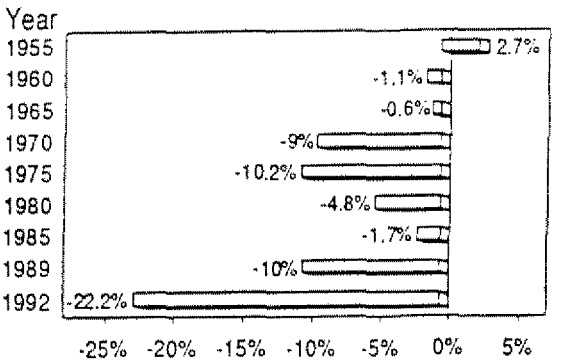


Figure 2: Percent Change in Patient Census From Previous Year in State Psychiatric Centers* (1955-1992)



*Data from 1955-1989 taken from 1991 New York State Statistical Yearbook (16th Edition). Data for 1992 taken from official Mental Health census reports.

Mr. Cooper, who had lived for more than 30 years in state hospitals, died within 90 days of his release. During his brief out-of-hospital experience, his basic health, mental health and hygienic needs were unmet and he was often dirty, unkempt and malodorous. Ms. Williams, who was mute, regressed and had lived in mental hygiene institutions for more than 40 years, assaulted and critically injured an elderly resident of the adult home to which she was discharged; the death was classified a homicide.

The justification for discharging Mr. Cooper and Ms. Williams, and hundreds of other long-term psychiatric patients released in the last five years, is that they "have received maximum benefit from hospitalization" and clinically no

[1] Pseudonyms.

longer require inpatient psychiatric hospitalization. This has probably been the case for many years, but the budgetary pressures are forcing staff to look more sharply at patients who have reached a clinical plateau. While this rationale is likely true for many patients, it is equally true that many long-term patients, like Mr. Cooper and Ms. Williams, are simply not ready to live outside the hospital without considerable support and supervision, which does not currently exist in most communities.

In fact, the same budgetary pressures that are influencing these discharges have also resulted in the inadequate development of supportive housing, supervised residences and other support services in the community for discharged patients. Thus, the psychiatric hospitals often rely on the lowest level of community services—adult homes and boarding homes—to serve discharged patients who are seriously mentally ill.

While there are patchworks of programs that perform specialized tasks for seriously mentally ill patients in many communities, there is no replacement for the asylum function that state hospitals have traditionally provided for the long-term patient. There is no single place to which patients can go to have all their needs met for food, clothing, shelter, and medical and psychiatric care; nor a reliable mechanism to assemble and deliver a comprehensive and dependable package of these services to them.[2]

Patients like Mr. Cooper and Ms. Williams, who have had a long history of psychiatric hospitalization, have lost much of their capacity for independent living and self direction, and the discharges occurring under fiscal pressures to meet census targets offers them little time to learn the skills they need. In any event, little effort is made to teach such skills.

Nor is there a reliable safety net in place. Instead, the patients are bounced between multiple health and mental health providers that see them briefly but provide no monitoring or ongoing supervision and follow-up to ensure their needs are being met. Not only are such services ineffective in meeting patients' needs, but they are expensive as well. Case management, which is expected to fill the void and assist in maintaining linkages, has proved simply unavailable or incapable of providing the level of intensity and advocacy that many patients require.

Patients like Mr. Cooper and Ms. Williams are at risk of being placed in marginal settings that, by law and design, lack the clinical and professional staff to monitor their health and mental health needs. Once there, they are at risk of neglect, deterioration and death.

The problems we found in the cases of Mr. Cooper and Ms. Williams illustrate the failings of individuals responsible for assuring appropriate hospital discharges and follow-up after discharge; for providing meaningful case management services; and for arranging and delivering appropriate medical and mental health care. These failings need to be corrected through a more comprehensive approach to discharge planning and follow-up of patients in the community. But, as importantly, the problems illustrate the predicaments caused by simultaneously cutting inpatient services and not investing adequately in community residential and support services to meet the needs of patients discharged from hospitals. This conundrum can only be solved jointly by the Executive and Legislative branches of government.

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[2] *Discharge Planning Practices of General Hospitals: Did Incentive Payments Improve Performance?*, NYS Commission on Quality of Care, April 1993.

This report represents the unanimous opinion of the members of the Commission. Responses to a draft of the report from the New York State Office of Mental Health, the New York State Department of Social Services, Brentwood Adult Home, and Southside Hospital are attached as Appendix A. On July 1, 1993, the draft report was also submitted to the operator of New Queen Esther Home for Adults; however, as of the date of this report, a response had not been received.

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Table of Contents

List of Figures

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Chapter I
Introduction

In July 1991, Nicholas Cooper,[3] a 73-year-old patient of Pilgrim Psychiatric Center, was deemed ready for discharge. After having lived for more than 40 years in various state psychiatric centers, the last 30 of which were spent in Pilgrim Psychiatric Center, Mr. Cooper was discharged to the Brentwood Adult Home in Suffolk County, Long Island, a 30-bed private, proprietary adult care facility certified by the State Department of Social Services (DSS).

That same month, 58-year-old Serina Williams was deemed ready for discharge by her Manhattan Psychiatric Center treatment team after having been a patient in various mental hygiene facilities for more than 40 years. Three months later, after having lived in Manhattan Psychiatric Center for 20 years, she too was placed in a private, proprietary adult care facility certified by the State Department of Social Services, the 47-bed New Queen Esther Home for Adults in Queens.

Within 90 days of his release from Pilgrim Psychiatric Center, Mr. Cooper was dead, and reports suggested he was not well cared for; reportedly, he was dirty, unkempt, and smelled of urine.

Both discharges ended in tragedy. Within 90 days of his release from Pilgrim Psychiatric Center, Mr. Cooper was dead, and reports received by the Commission from various parties who had contact with him in the weeks prior to his death suggested that Mr. Cooper was not well cared for; reportedly, he was dirty, unkempt, and smelled of urine. Approximately one year after her October 1991 release from Manhattan Psychiatric Center, Ms. Williams assaulted and critically injured another mentally ill resident of the adult home who subsequently died. The death was ruled a homicide, and the Commission received reports that no staff were on duty at the time of the assault.

Approximately one year after her October 1991 release from Manhattan Psychiatric Center, Ms. Williams assaulted and critically injured another mentally ill resident of the adult home who subsequently died.

Pursuant to Article 45 of Mental Hygiene Law, the Commission on Quality of Care for the Mentally Disabled and its Mental Hygiene Medical Review Board commenced investigations into the circumstances surrounding the deaths, focusing on the clinical histories of Mr. Cooper and Ms. Williams, the appropriateness of their discharges, the conditions in the adult homes to which they were released, and the adequacy of their post-discharge services. During the investigations, Commission staff:

[3] All names in this report have been changed to protect the individuals' confidentiality.

- reviewed clinical records pertaining to Mr. Cooper's and Ms. Williams' inpatient histories and interviewed staff responsible for their care at Pilgrim and Manhattan Psychiatric Centers;
- reviewed clinical records and interviewed staff of the mental health outpatient programs to which Mr. Cooper and Ms. Williams were referred upon their discharge;
- reviewed Department of Social Services' certification records on the Brentwood and New Queen Esther Adult Homes and spoke with DSS personnel about conditions and incidents in the homes and their certification histories;
- conducted site visits to the Brentwood Adult Home and the New Queen Esther Home for Adults to observe conditions, interview staff and residents, and review relevant records maintained by the facilities;[4] and
- interviewed and reviewed the records of ancillary service providers who had contact with Mr. Cooper and Ms. Williams, including private physicians, hospital personnel, and police officials.

Chapter II and Chapter III present the case studies of Mr. Cooper and Ms. Williams, respectively. The Commission's conclusions and recommendations, based on its investigations, are presented in Chapter IV.

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[4] Although Mr. Cooper was an outpatient of a mental hygiene facility at the time of his death and Mental Hygiene Law authorizes the Commission to investigate the deaths of mental hygiene service recipients, Commission staff were initially denied access to the Brentwood Adult Home, the DSS-certified facility in which he lived. Legislation was enacted in June 1992 (Chapter 266 of the Laws of 1992) specifically clarifying the Commission's authority to visit DSS-certified adult care facilities and to obtain information in the course of investigating deaths of mental hygiene patients. This legislation paved the way for the continuation of the investigation into Mr. Cooper's death and access to the facility in which he lived.

Chapter II
Nicholas Cooper

Nicholas Cooper was born on August 5, 1917 in Brooklyn, New York. Information on Mr. Cooper's early history was limited; however, according to clinical records, Mr. Cooper worked as a laborer and was a member of the International Handbag and Luggage Union. Record notes also indicated that Mr. Cooper had two brothers and a sister, but that he had had no contact with them since 1956 when he was admitted to Creedmoor Psychiatric Center.

Thirty-Five Years in Institutions

This admission to Creedmoor Psychiatric Center on an Order of Certification from Kings County Hospital, at age 39, marked Mr. Cooper's first involvement with the mental health system. Mr. Cooper's clinical records indicated that, upon admission, he had delusions of persecution, was rambling and incoherent, and had impaired judgment (Figure 3).

According to his clinical records, Mr. Cooper's condition and symptoms remained essentially unchanged during his 30 years of confinement at Pilgrim Psychiatric Center.

In October 1957, approximately one year after his admission to Creedmoor Psychiatric Center, Mr. Cooper was transferred to Rockland Psychiatric Center, and approximately four and a half years later, at the age of 44, Mr. Cooper was transferred to Pilgrim Psychiatric Center, where he lived for almost 30 years. At the time of his admission to Pilgrim Psychiatric Center, Mr. Cooper was described as sloppy and in need of constant supervision from staff, and clinical notes indicated that he lacked insight and continued to have paranoid delusions.

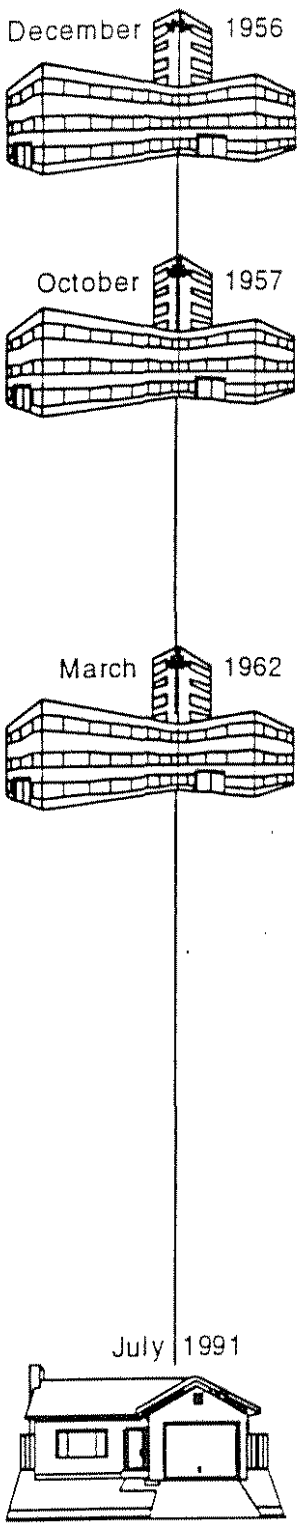
According to his clinical records, Mr. Cooper's condition and symptoms remained essentially unchanged during his 30 years of confinement at Pilgrim Psychiatric Center. Pilgrim records for 1990–1991 indicated that Mr. Cooper received psychotropic medications for his psychiatric condition, and he was offered the opportunity to attend recreational activity programs, individual and group discussion sessions, and mini-workshop programs. Reportedly, Mr. Cooper also had the freedom to wander the center's grounds during most of his hospitalization. Other record notes indicated, however, that he continued to be seclusive, suspicious, and delusional, and that he did not want to attend the groups and activities offered.

Mr. Cooper enjoyed good health during his several decades of institutionalization. His only physical problem of note arose in 1989 when, at the age of 72, he developed hypertension which was treated with a low-salt diet and medication.

Little Progress (1962-1991)

Over his many years at Pilgrim Psychiatric Center, clinical records revealed little intention to consider Mr. Cooper's discharge. To the contrary, his clinical records, as well as staff interviews, generally suggested that most people involved with Mr. Cooper's care considered Pilgrim to be Mr. Cooper's long-term home.

Figure 3: Significant Events in Mr. Cooper's Life 1956-1991



Admitted to Creedmoor Psychiatric Center

10 months later . . .

Transferred to Rockland Psychiatric Center

4 1/2 years later . . .

Transferred to Pilgrim Psychiatric Center

29 years later . . .

Discharged to Brentwood Adult Home

This premise was reflected in Mr. Cooper's annual psychiatric assessments up through July 1991.

On January 22, 1991, Mr. Cooper's treatment team met and agreed that Mr. Cooper had not "shown improvement since [his] last treatment plan" and that he continued to believe that he was an employee of the hospital, the FBI, and the CIA. Mr. Cooper's January 1991 treatment plan also indicated that he did not meet discharge criteria and that discharge would be considered "when [his] delusional ideation doesn't interfere with his ability to accept realistic discharge plans and he gains independence with grooming skills and participates in activities." The tentative discharge date, recommended by the treatment team, was January 22, 1992.

On July 17, 1991, Mr. Cooper's social worker entered a note in Mr. Cooper's record stating "Nicholas' tentative discharge date is for July 25, 1991 at 10:00 a.m."

Three months later, on April 20, 1991, Mr. Cooper's treatment team met again for a periodic treatment plan review to evaluate Mr. Cooper's progress and service needs. According to the meeting minutes, the treatment team again determined that Mr. Cooper had not yet attained discharge criteria.

At around this same time, progress notes in Mr. Cooper's record stated that Mr. Cooper was experiencing behavioral problems and was not complying with the unit's rules or the hours prescribed on his grounds privileges honor card. On seven occasions between April 2, 1991 and July 25, 1991 (the date of his discharge), Mr. Cooper left the facility without consent, and on three of these occasions his grounds privileges were rescinded. Other record notes for this period reported that Mr. Cooper was hostile and verbally aggressive, swearing at staff. On two separate occasions on April 29, 1991, record notes also stated that Mr. Cooper had accused staff of "smacking" him in the mouth and punching him in the stomach. His record is silent on any follow-up of these allegations of staff abuse.

On July 18, 1991, the treatment team conducted another periodic treatment plan review and again determined that Mr. Cooper "did not meet discharge criteria." The clinical team's review of Mr. Cooper's treatment goals indicated that he had not made any significant progress and that he continued to be "isolated and unmotivated...[and] does not voluntarily seek out group schedules." The notes also stated that Mr. Cooper still needed reminders from staff to change his clothes and that he had not established a trusting relationship with anyone.

Ready for Discharge?

Despite these continuing notes by Mr. Cooper's treatment team through July 18, 1991 indicating that he did not meet discharge criteria and that he continued to have behaviors that would interfere with an easy transition to a less supervised setting, notes commencing on July 17, 1991 suddenly asserted that he was ready for discharge (Figure 4).

On July 18, 1991, the treatment team conducted another periodic treatment plan review and again determined that Mr. Cooper "did not meet discharge criteria."

On July 17, 1991, Mr. Cooper's social worker entered a note in Mr. Cooper's record stating "Nicholas' tentative discharge date is for July 25, 1991 at 10:00 a.m." Two days later, and one day after the above treatment review meeting, Mr. Cooper's psychiatrist, who had reportedly

Figure 4: Excerpts From Pilgrim's Record Notes: Year Prior to Discharge

January 18, 1991 – Social Assessment

He has basically remained the same in the past year. He is still delusional, believing that he is employed by the FBI and CIA. He continues to be suspicious of others and does not wish to establish relationships . . . When his overall level of functioning improves, he will be discharged into Family Care.

January 21, 1991 – Psychiatric Assessment

He is seclusive, suspicious, and delusional; states that FBI is watching him . . . poor social skills . . . prognosis is guarded due to chronic nature of his illness.

January 22, 1991 – Comprehensive Treatment Plan Review

Pt. has not shown improvement since last Tx [treatment] Plan.

February 12, 1991 – Activities Assessment

This pt.'s behavior has remained unchanged in the past year. . . problems: delusional, has hallucinations, hoards garbage, his ADL [Activities of Daily Living] is poor.

April 20, 1991 – Periodic Treatment Plan Review

Discharge plans, service needs, and discharge criteria reviewed today. Patient has not attained discharge criteria at this time.

May 7, 1991 – Psychiatrist's Progress Note

Patient is suspicious, seclusive, and manipulative. He becomes hostile and verbally aggressive . . . A.C. [alternative care] placement is not considered.

June 4, 1991 – Unit Staff's Progress Note

[Patient] needs supervision with his ADL. Will not shower or shave or change his clothes on his own . . . does not attend any activities on or off ward.

July 17, 1991 – Social Worker's Progress Note

[Patient's] tentative discharge date is for 7/25/91 at 10 AM.

July 18, 1991 – Periodic Treatment Plan Review

All goals and objectives have been extended . . . Pt. is isolated and unmotivated. He does not voluntarily seek out group schedules. No progress . . . Pt. has not established a trusting relationship with anyone. No progress . . . Pt. still needs reminders from staff to change his clothes. No progress . . . ***Discharge plan remains same. He does not meet discharge criteria*** *[emphasis added].*

July 19, 1991 – Psychiatrist's Progress Note

Patient is pleasant and cooperative. He is in good contact with his direct surroundings, well-oriented . . . A.C. placement is considered with continued medication, supervision, and follow-up care.

July 25, 1991 – Nursing Transfer/Discharge Note

Mood and Affect: pleasant, cooperative. Mood anxious, suspicious of others—delusional thoughts [and] grandious [sic] ideas. Thought Patterns: Believes he is rich and 100 years old and is paid to smoke 10 packs of cigarettes a day.

July 25, 1991 – Discharge Summary

Patient is well oriented to time, place, and persons and is in good contact with his direct surroundings. It was considered that this patient received maximum benefit from this hospitalization and he will be able to readjust to an alternate care placement program.

participated in his recent treatment team reviews, wrote in Mr. Cooper's record:

> *Patient is pleasant and cooperative. He is in good contact with his direct surroundings, well oriented . . . A.C. [alternate care] placement is considered with medication, supervision, and follow-up care.*

On July 25, 1991, the date of Mr. Cooper's discharge, this same psychiatrist signed Mr. Cooper's discharge plan and summarized that:

> *It was considered that this patient received maximum benefit from this hospitalization and he will be able to readjust to an alternate care placement program with supervision, medications, and follow-up care.*

Upon interview with Commission staff, Mr. Cooper's social worker and psychiatrist were asked to explain their apparently contradictory and unsupported notes. Both of these clinicians indicated that during this seven day period, Mr. Cooper must have improved and attained discharge criteria, although they offered no supporting evidence and could not explain the lack of supporting documentation in his record. Mr. Cooper's psychiatrist also added that Mr. Cooper had achieved "maximum benefit from his hospitalization and was ready for discharge."

Consistent with other clinical notes and assessments in Mr. Cooper's record, however, the July 25, 1991 Nursing Discharge Note states:

> *Mood and Affect: pleasant, cooperative. Mood anxious, suspicious of others—delusional thoughts [and] grandious [sic] ideas. Thought Patterns: Believes he is rich and 100 years old and is paid to smoke 10 packs of cigarettes a day.*

Mr. Cooper's Discharge

On July 25, 1991, Mr. Cooper, now 73 years old, was discharged from Pilgrim Psychiatric Center to Brentwood Adult Home, a 30-bed adult home facility located in Suffolk County, Long Island. At the time of his discharge, this adult home facility was certified by the State Department of Social Services; however, inspections by the Department over the past 10 years (1982–1991) indicated that it had many serious recurring problems. Indeed, the home had received noncompliance ratings from the Department on each of its complete inspections since 1982 (Figures 5 and 6).

Upon discharge, Mr. Cooper's psychiatric diagnosis was "schizophrenia paranoid chronic type," and his medical diagnosis was "hypertension, benign prostatic hypertrophy, dorsal scoliosis, and seborrheic dermatitis of the scalp."

Figure 5: DSS Complete Inspections for Brentwood Adult Home 1982-1991

Year	DSS Rating
1982	Noncompliance
1982	Noncompliance
1982[1]	Noncompliance
1983	Noncompliance
1984[1]	Noncompliance
1984[1]	Noncompliance
1985[1]	Noncompliance
1985[1]	Noncompliance
1986	Noncompliance
1987[1]	Noncompliance
1988[1]	Noncompliance
1988	Noncompliance
1989	Noncompliance
1990[1]	Noncompliance
1991	Noncompliance
1991	Noncompliance

[1] DSS conducted a complete and a follow-up inspection during the complete inspection visit.

On the day of his discharge a physical examination report also stated that Mr. Cooper was "a well developed and well nourished white male, not in acute distress." All medical evaluations (e.g., electrocardiogram, complete blood count, x-rays, audiological test) were also within normal limits.

Mr. Cooper's discharge plan included reference to a specific appointment at the Brentwood Mental Health Clinic (August 1, 1991) and a general referral to the Brentwood Family Health Center to address his medical problems.[5] Mr. Cooper's record also stated that on the date of his discharge, his social worker made a specific appointment for Mr. Cooper at the Brentwood Family Health Center for August 2, 1991.

On the day of his discharge, a social worker from Pilgrim Psychiatric Center also contacted Catholic Charities Community Support Services to refer Mr. Cooper for case management services.[6]

At the time of discharge, Mr. Cooper was prescribed Haldol, 8 mg. twice a day, Minipress, 1 mg. every eight hours, a multivitamin once a day, and Zetar Shampoo, three times a week. He was also prescribed a 3600 calorie, 4 mg. sodium chopped diet. On the day of his discharge, Mr. Cooper received a 28-day supply of these physician-prescribed medications.

Thus, on July 25, 1991, after living for nearly 30 years at Pilgrim Psychiatric Center, Mr. Cooper moved to the Brentwood Adult Home, armed with aftercare appointments for medical and mental health care, a referral for

Figure 6: Serious Recurring Problems in DSS Inspection Reports for Brentwood Adult Home (1982-1991)

- The operator does not employ an approved full-time administrator (1984, 1985, 1989, 1990, 1991).
- There is no authorization in medication management records for the change in schedule of administration of physician-prescribed medications (1982, 1984, 1985, 1988, 1990, 1991).
- Physician-prescribed diet orders are not included in the facility's menu (1985, 1986, 1990, 1991).
- A staff person trained in basic first aid is not present on each shift (1982, 1984, 1985, 1988, 1989, 1990).
- Exit/smoke barrier doors do not self-close (1982, 1988, 1990, 1991).
- Physician-prescribed medications are not accurately recorded, and residents are assisted with medications without the assistance being recorded (1989, 1990, 1991).
- The operator is not maintaining an organized and diversified program of individual and group activities (1985, 1987, 1989, 1990, 1991).
- The operator failed to provide each resident with a personal allowance account statement at least quarterly (1983, 1990, 1991).

[5] The Brentwood Mental Health Clinic and the Brentwood Family Health Center are operated by Suffolk County's Department of Health Services.

[6] In a telephone conversation with Commission staff on April 22, 1993, a staff person of Pilgrim Psychiatric Center's Outpatient Services Department reported that on the day of Mr. Cooper's discharge, he had also been referred to Suffolk County's Department of Social Services' Adult Protective Services (APS) Program for case management and follow-up. Reportedly, staff of this program had also been invited to attend Mr. Cooper's discharge planning meeting, but for unknown reasons did not attend. On April 22, 1993, the Commission contacted Adult Protective Services regarding these referrals, but they maintained that they had not been apprised of Mr. Cooper's discharge and that Mr. Cooper had not been referred to APS for services.

case management services offered by Catholic Charities Community Support Services' team, and physician prescribed-prescriptions for four medications, and a special high-calorie, low-sodium, chopped diet.

Mr. Cooper's First Month Post-Discharge

According to Brentwood Adult Home's case management records, during Mr. Cooper's first week at Brentwood, he was very sociable with other residents and spent his days walking in the community. One week after his admission, on August 1, 1991, Mr. Cooper attended a screening appointment at the Brentwood Mental Health Clinic. According to the clinic's admission screening note, Mr. Cooper was alert, friendly, and talkative during the intake assessment. He spent most of the interview discussing how he had been assigned to special reconnaissance flights over Japan for the purpose of taking photographs in cloud-covered weather as fair weather would enable the Japanese to shoot him down (Figure 7).

Based on the interview, Mr. Cooper was diagnosed "schizophrenia paranoid chronic" and "seriously and persistently mentally ill." According to the clinic's Patient Prescription Record, at the conclusion of this session, the therapist slightly reduced Mr. Cooper's psychotropic medication (Haldol) from 8 mg. twice a day to 5 mg. in the morning and 10 mg. at the hour of sleep and made no other treatment recommendations. The therapist provided no notes explaining why he had reduced Mr. Cooper's medications.[7]

Two and a half weeks after his admission, on August 12, 1991, the Catholic Charities Community Support Services' case manager met Mr. Cooper for the first time at Brentwood Adult Home. According to the case manager's notes, during this meeting, Mr. Cooper was friendly and coherent, but not a reliable informant. Mr. Cooper stated that he had a brother and a sister, was never married, served in World War II, and attended New York University's School of Languages. He also reported how he delivered important documents for the Pentagon and how the FBI continued to watch him. The case manager recorded that Mr. Cooper was motivated to enroll in a day program and was eager to attend "veteran's parties."

Mr. Cooper's record provides no documentation indicating that the case manager followed up with either of the two referrals she reportedly made and, by all reports, Mr. Cooper never benefited from these services.

In response to his interest in attending parties, the case manager referred Mr. Cooper to a fellow adult home resident for additional information. The case manager also reportedly made a referral for Mr. Cooper to the Office of Vocational Rehabilitation for participation in a work program. Mr. Cooper's record provides no documentation indicating that the case manager followed up with either of the two referrals she reportedly made and, by all reports, Mr. Cooper never benefited from these services. There is also no documentation that the case manager made any referrals for Mr. Cooper to an Office of Mental Health certified or funded day program or psychosocial club, which would appear to have been more able to meet his needs.

[7] According to Brentwood Adult Home's August 1991 Medication Administration Record, Mr. Cooper did not start receiving his slightly modified dosage of Haldol until August 29, 1991, nearly one month after the new order.

Figure 7: Mr. Cooper's Mental Health Aftercare Services (90 Days Post-Discharge)

Date	Service
July 25	Discharged from Pilgrim Psychiatric Center
August 1	Brentwood Mental Health Clinic ▫ Admission screening
August 12	Catholic Charities Community Support Services ▫ Home visit for intake assessment
August 22	Brentwood Mental Health Clinic ▫ 30-minute individual therapy session
September 19	Brentwood Mental Health Clinic ▫ 30-minute individual therapy session
September 26	Catholic Charities Community Support Services ▫ Telephone contact with Southside Hospital
September 27	Catholic Charities Community Support Services ▫ 30-minute visit to Southside Hospital
October 11	Catholic Charities Community Support Services ▫ Transport Mr. Cooper to Brentwood Medical Health Center
October 17	Brentwood Mental Health Clinic ▫ 30-minute individual therapy session
October 22	Deceased

Total = 8 contacts (approximately 5 hours of service)

On August 22, 1991, 28 days after his discharge, Mr. Cooper attended his follow-up appointment at the Brentwood Mental Health Clinic. Progress notes concerning this 30-minute individual session indicated that Mr. Cooper was delusional, not fixated to a topic, and telling the therapist various stories which he had created. At the conclusion of this session, the therapist gave Mr. Cooper a refill for his medications and a follow-up appointment for September 19, 1991, almost one month later.

Of note, during this month, Mr. Cooper's first 30 days away from Pilgrim Psychiatric Center after a nearly 30-year period of residence, no staff from Pilgrim Psychiatric Center

made any contact with Mr. Cooper, the Brentwood Adult Home staff, or his mental health case manager, to ascertain his well-being or the implementation of his discharge plan. Pilgrim Psychiatric Center's staff did, however, report that they had contacted Brentwood Mental Health Clinic at the end of August to ascertain if Mr. Cooper had attended his initial clinic appointment.

During this month, Mr. Cooper's first 30 days away from Pilgrim Psychiatric Center after a nearly 30-year period of residence, no staff from Pilgrim Psychiatric Center made any contact with Mr. Cooper.

Mr. Cooper's Second Month Post-Discharge

According to Brentwood Adult Home's records and staff, during his second month in the home, Mr. Cooper spent his days walking alone in the community or hanging out at local shopping plazas. On occasion, store owners would call Brentwood Adult Home to request that staff escort Mr. Cooper home. Record notes also indicated that Mr. Cooper required reminders to shave, shower, and change his clothes.

On September 19, 1991, Mr. Cooper attended his third appointment at the Brentwood Mental Health Clinic. The therapist's notes from this 30-minute session stated, "Expansive and paranoid idea much less. Appears to be more a person undergone mental deterioration and when excited old trait returns [sic]." The only treatment recommendation emanating from the session was a modest increase in Mr. Cooper's Haldol from 15 mg. each day to 20 mg. each day. Mr. Cooper also received a follow-up appointment for October 17, 1991.[8] Aside from the above note, no rationale for this medication change was found.

On September 24, 1991, Mr. Cooper attended the Brentwood Family Health Center to have his blood pressure medication (Minipress) and multivitamin prescriptions refilled. This was Mr. Cooper's first medical appointment since his discharge, as he had for unknown reasons failed to attend the August 2, 1991 clinic appointment arranged by Pilgrim Psychiatric Center at the time of his discharge. According to clinic records, Mr. Cooper's general appearance was noted as "dirty, unkempt, [and] smelly." During an interview with Commission staff, the clinic's physician stated that since Mr. Cooper was not a regular patient, he did not receive a comprehensive medical examination.

Things Fall Apart

The next day, September 25, 1991, at 8:30 p.m., Mr. Cooper fell in his bedroom, cutting his head. The home's staff contacted an ambulance, and Mr. Cooper was transferred to Southside Hospital's Emergency Room for medical treatment. According to the Emergency Department Triage Record, Mr. Cooper was alert, but confused and had a three-inch laceration on his

[8] According to Brentwood Adult Home's September Medication Administration Record, Mr. Cooper's new medication order was administered on September 21, 1991; however, for the first two days (September 21 and September 22) Mr. Cooper received both the new and old dosages at 9:00 a.m. and 8:00 p.m. This documentation indicates that Mr. Cooper received a total daily dose of 35 mg., nearly twice his prescribed dosage. On September 23 and 24, 1991 at 9:00 a.m., the home's staff gave Mr. Cooper both the new and old dosages of his psychotropic medication. At 8:00 p.m. he received only the new dosage. The home's medication records indicated that by September 25, 1991, Mr. Cooper finally began receiving the correct dosage of Haldol.

scalp. The triage report also stated that Mr. Cooper was experiencing constant extrapyramidal movements and was unkempt and incontinent of urine.

The physician explained that Mr. Cooper was admitted not only for medical care, but because "his body was completely filthy," and "it looked as if he hadn't washed in several weeks."

The emergency room physician examined Mr. Cooper and sutured his scalp laceration with seven stitches. Tests conducted also revealed that Mr. Cooper had a fever of 102.5° and a high white blood cell count of 25,000 (normal range: 4,500–11,000). The physician admitted Mr. Cooper to the hospital with a diagnosis of "community acquired pneumonia."

Upon interview, the physician explained to Commission staff that Mr. Cooper was admitted not only for medical care, but because "his body was completely filthy," and "it looked as if he hadn't washed in several weeks." The physician also indicated that Mr. Cooper had urine all over his pants, and that even though the home's staff had accompanied him to the emergency room, it appeared that no one was really caring for him.

The day after his admission, on September 26, 1991, Mr. Cooper's Catholic Charities Community Support Services' case manager contacted the hospital to inquire about his condition. Hospital staff reportedly told the case manager that Mr. Cooper's head injury was not very serious, but that he had been admitted to the hospital to rule out pneumonia. During this telephone call, the case manager also spoke briefly to Mr. Cooper.

The next day, the case manager went to the hospital to visit Mr. Cooper. This was only the second time since Mr. Cooper's July 25, 1991 discharge from Pilgrim Psychiatric Center that she had met with Mr. Cooper.[9] During the 30-minute visit, the case manager was informed by hospital staff that Mr. Cooper was admitted with a fever of 102° and that his hygienic condition was deplorable. Hospital staff reportedly suspected neglect. The case manager also spoke with Mr. Cooper's physician who reported the same concerns.

In response to these reports, on September 27, 1991, the Catholic Charities Community Support Services' case manager contacted the State Department of Social Services and left a message requesting that an inspector call her. Six days later, on October 3, 1991, a DSS inspector contacted the case manager.

The case manager also contacted the Commission to report her concerns that the adult home was not providing residents assistance in daily living and that one resident, Mr. Cooper, was recently admitted to the hospital, and a physical examination indicated his hygiene was "atrocious." Commission staff advised the case manager to contact the Department of Social Services, which has primary responsibility for the certification and oversight of adult homes. In a follow-up telephone call, the case manager reported to Commission staff that she was in-

The case manager was informed that Mr. Cooper was admitted with a fever of 102° and that his hygienic condition was deplorable. Hospital staff reportedly suspected neglect.

[9] According to a September 20, 1991 progress note in Mr. Cooper's record, whenever the case manager visited Brentwood Adult Home, Mr. Cooper was not around. There was no documentation that the case manager had made any special efforts to meet with Mr. Cooper or to seek him out in the community.

formed by the Department of Social Services that Department staff would visit the home.

On October 18, 1991, two weeks after the complaint was reported and four days prior to Mr. Cooper's death, the Department of Social Services conducted a partial inspection and complaint investigation at Brentwood Adult Home.

In addition, record notes indicated that on October 4, 1991, the case manager's supervisor contacted the administrator of the Brentwood Mental Health Clinic to inform him of Mr. Cooper's hospitalization and the hospital's allegation that there may be "some neglect on the part of the Brentwood Adult Home." Reportedly, the Catholic Charities Community Support Services' supervisor informed the clinic of Mr. Cooper's appearance upon admission to the hospital and that he was "disheveled and dirty . . . [and] his feet were black with dirt." Record notes also indicated that during this conversation, they discussed the case manager's contacts with the Commission and, at the conclusion of the conversation had agreed that they "would keep in touch." Mr. Cooper's record provides no documentation indicating that the Community Support Services Program conducted any additional follow-up with the Brentwood Mental Health Clinic.

On October 18, 1991, two weeks after the complaint was reported and four days prior to Mr. Cooper's death, the Department of Social Services conducted a partial inspection and complaint investigation at Brentwood Adult Home. According to this report, the Department of Social Services' staff person spoke with Brentwood's administrator (who had worked at the home for only two weeks) and the cook at the home and reviewed the home's case management records. She also met briefly with Mr. Cooper in his bedroom. The cook reported that, for a couple of weeks, Mr. Cooper had been resistant to caring for his personal hygiene. The Department staff person's report also stated, however, "Even thought [sic] it is very likely that resident's appearance when at the hospital was as described, his appearance this date was quite acceptable. Complaint not substantiated."

There is no indication in the report that the Department's staff person made any contact with Southside Hospital. Subsequently, the Department's staff person failed to discover that medical personnel at the Southside Hospital's Emergency Room had found Mr. Cooper's personal hygiene condition poor, not just on one occasion (September 25, 1991), but also on October 9, 1991 and on October 16, 1991. (See Report pp. 14 and 15.) Additionally, as the Department's staff person apparently made no contact with personnel from the Brentwood Mental Health or Family Health Clinics who were also serving Mr. Cooper, she did not discover that these providers had noted his poor personal condition on several occasions (September 24, and October 11, 1991). (See Report pp. 11 and 14.)

Again, throughout Mr. Cooper's second month at the Brentwood Adult Home, there was no documentation that Pilgrim Psychiatric Center staff made any contact with Mr. Cooper.

Again, throughout Mr. Cooper's second month at the Brentwood Adult Home, there was no documentation that Pilgrim Psychiatric Center staff made any contact with Mr. Cooper, staff at the Brentwood Adult Home, or any staff of his mental health providers to check on his progress post-discharge.

The discharging physician offered no other explanation why Mr. Cooper was being discharged back to the Brentwood Adult Home, despite the hospital's initial concerns regarding the home's neglect of his care and supervision.

Mr. Cooper's Last Month

After a nine-day inpatient stay, on October 3, 1991, Mr. Cooper was discharged from Southside Hospital back to Brentwood Adult Home. Upon discharge, Mr. Cooper received a prescription for Erythromycin, 500 mg. four times a day, for ten days and a follow-up appointment for October 8, 1991 at the Brentwood Family Health Center to have his sutures removed. The Brentwood Family Health Center was also copied in on Mr. Cooper's discharge summary.

In an interview with Commission staff, the discharging physician indicated that at the time of discharge, Mr. Cooper was medically and psychiatrically stable and that he "looked good." The discharging physician offered no other explanation why Mr. Cooper was being discharged back to the Brentwood Adult Home, despite the hospital's initial concerns regarding its neglect of his care and supervision. According to Brentwood Adult Home's records, Mr. Cooper's discharge summary and prescriptions were received by the home's staff.

Six days later, on October 9, 1991 at around 5:00 p.m., Mr. Cooper was walking alone in the community and fell. Bystanders who witnessed the accident called an ambulance and, when the ambulance arrived, Mr. Cooper was found sitting on the curb. Mr. Cooper was brought to Southside Hospital's Emergency Room for evaluation.

According to the emergency room record, Mr. Cooper appeared alert, but unkempt, and still had the sutures in his scalp that he had received two weeks prior. Mr. Cooper was admitted to the emergency room at 6:18 p.m. and a physical examination, blood work, and a chest x-ray were completed. The examination report indicated that Mr. Cooper was "filthy" upon admission, and had mild shakes of both hands. The hematology work-up revealed several abnormalities, including a high white blood cell count of 23,700, substantially elevated from his last laboratory results of 8,100 conducted at the end of his previous hospitalization. Notably, both the physician and triage nurse were the same medical personnel that had examined Mr. Cooper during his previous emergency room examination.

Despite these lab values and Mr. Cooper's apparent physical condition, at 3:05 a.m. Mr. Cooper was discharged from Southside Hospital's Emergency Room back to the Brentwood Adult Home with a diagnosis of "possible right lung pneumonia." At the time of discharge, Mr. Cooper received an instruction sheet stating that he should follow up with his private doctor within one to two days and that he should drink plenty of fluids. Upon discharge, Mr. Cooper also received a prescription for Erythromycin, 250 mg. four times a day for ten days. According to Brentwood Adult Home's medication management records, this prescription was appropriately filled and administered. The hospital, which had originally recommended that Mr. Cooper have his sutures removed two days before on October 8, 1991, did not remove his sutures prior to his discharge.

The following day, October 11, 1991, Mr. Cooper's case manager escorted him to the Brentwood Family Health Center to have his sutures removed. This appointment was arranged by the case manager upon recommendation by the Commission, which had continued to monitor Mr. Cooper's care weekly through telephone contact with Mr. Cooper's physicians and case manager. According to the notes of the health

clinic's physician, on the day of the examination, Mr. Cooper was "extremely unkempt," and his "clothes were extremely dirty."

The case manager reported that the home's staff told her to call the home before visiting so they could make sure that Mr. Cooper bathes and is clean before she visits.

The case manager also told the Commission during a telephone conversation that Mr. Cooper's hygiene was very poor and that she had spoken with him about taking care of his personal hygiene. In response, Mr. Cooper indicated that he bathed twice a week at the adult home. The case manager then suggested to Mr. Cooper that he bathe every day. Mr. Cooper reportedly agreed and indicated that he could do so independently.

According to the case manager's notes, after returning from the health clinic, she spoke with an aide at the home about making sure that Mr. Cooper bathes. Upon later interview with Commission staff, the case manager reported that in response to her suggestion, the home's staff told her to call the home before visiting so they could make sure that Mr. Cooper bathes and is clean before she visits.

Recurrent Hospital Visits

Five days later, on October 16, 1991, Mr. Cooper again fell at Brentwood Adult Home. The home's staff called for an ambulance and, at 5:50 p.m., Mr. Cooper was transferred to Southside Hospital's Emergency Room for evaluation. According to the emergency room record, Mr. Cooper was complaining of lower back pain, and he was unkempt and foul smelling. The emergency room physician evaluated Mr. Cooper, and x-rays were taken which revealed no fractures (Figure 8).

Four and a half hours later, at 10:30 p.m., Mr. Cooper was discharged back to Brentwood Adult Home with a Patient Instructions Form stating that he should make an appointment with Brentwood Family Health Center for follow-up care and that warm compresses should be applied for 15 minutes, four times a day for the next two days. Mr. Cooper also received a prescription for Motrin, 800 mg. three times a day for pain.

According to the home's medication management records, Mr. Cooper received his medication three times a day from October 17 through 22. There were no notes in the home's records indicating that the doctor's order for warm compresses was ever implemented. Interviews with the home's operator and direct care staff also indicated that they could not recall whether these orders were ever carried out.

The next day Mr. Cooper attended his fourth appointment at the Brentwood Mental Health Clinic. According to the therapist's progress notes, during the 30-minute individual session, Mr. Cooper focused on his made-up stories, telling his therapist that he keeps the stories to himself as a secret. Record notes stated that the therapist had consistently counseled Mr. Cooper not to tell other people these stories. During this visit, the therapist's notes also stated that Mr. Cooper had facial twitches and hand and finger tremors.

There were no notes in the home's records indicating that the doctor's order for warm compresses was ever implemented.

Despite the above symptoms, which were likely side effects of his psychotropic medications, there was no documentation indicating that Mr. Cooper's medications were reevalu-

Figure 8: Mr. Cooper's Medical Aftercare Services (90 Days Post-Discharge)

July 25	Discharged from Pilgrim Psychiatric Center
September 24	Brentwood Family Health Center ▫ Prescription refill
September 25-October 3	Southside Hospital Admission ▫ Diagnosis: community acquired pneumonia and scalp laceration ▫ Nine-day stay
October 9	Southside Hospital Emergency Room ▫ Admitted at 6:18 p.m. Discharged at 3:05 a.m. ▫ Diagnosis: possible right lung pneumonia
October 11	Brentwood Family Health Center ▫ Removal of seven stitches
October 16	Southside Hospital Emergency Room ▫ Admitted at 6:37 p.m. Discharged at 10:30 p.m. ▫ Diagnosis: chronic degenerative arthritis
October 18	Southside Hospital Emergency Room ▫ Admitted at 8:36 p.m. Discharged at 12:30 p.m. (approximate) ▫ Diagnosis: lumbosacral strain
October 21	Southside Hospital Emergency Room ▫ Admitted at 2:17 p.m. Discharged at 6:15 p.m. ▫ Diagnosis: thoracic scoliosis
October 22	Southside Hospital Emergency Room ▫ Admitted at 3:08 p.m. ▫ Pronounced dead at 3:18 p.m.

ated, although he received a prescription to have them refilled. There were also no notes indicating why the therapist chose not to treat Mr. Cooper's apparent side effects from his psychotropic medications. Mr. Cooper also received a follow-up appointment for November 14, 1991.

Two days later, on October 18, 1991, Mr. Cooper fell for a fourth time—this time off his bed at Brentwood Adult Home. Staff of the home escorted Mr. Cooper back to Southside Hospital for evaluation.

At 8:36 p.m., Mr. Cooper was admitted to the emergency room for evaluation and x-rays. Sometime after midnight, Mr. Cooper was discharged back to Brentwood Adult Home with a diagnosis of "lumbosacral strain." Mr. Cooper also received a Patient Instructions Form stating that he should follow up with the Brentwood

Medical Center within two to three days and that he should take Advil every four hours for pain, rest in bed for two days, apply cold compresses for 15 minutes, four times a day for one day, and apply warm compresses for 15 minutes, four times a day for two days. Records of Brentwood Adult Home indicate that Mr. Cooper received Advil three times a day from October 18 through October 22, but there is no documentation that the cold or warm compresses were applied.

Mr. Cooper was found lying in the fetal position in bed, complaining that he had fallen Friday night and that his back still hurt.

According to Brentwood Adult Home's records, three days later, on Monday, October 21, 1991, Mr. Cooper requested to go back to the hospital because he was in pain. In response to Mr. Cooper's request, the home's staff called an ambulance. According to the report completed by the ambulance driver, Mr. Cooper was found lying in the fetal position in bed, complaining that he had fallen Friday night and that his back still hurt. At approximately 1:15 p.m., he was transferred back to Southside Hospital's Emergency Room for evaluation.

The emergency room physician examined Mr. Cooper, and x-rays were taken which revealed "dextroscoliosis of the thoracic spine probably congenital in origin." At 6:15 p.m., Mr. Cooper was discharged back to Brentwood Adult Home with a diagnosis of "thoracic scoliosis" and a Patient Instructions Form stating that he should apply heat to his back, have bed rest, and follow up with his private doctor within two days.

Mr. Cooper Dies

The next morning Mr. Cooper stayed in bed, only getting up on two occasions to use the bathroom. During the late morning, an aide in the home went to Mr. Cooper's bedroom to check on him. Reportedly, Mr. Cooper indicated that he wanted to remain in bed to rest. The aide noticed Mr. Cooper had drooled on his pillow, so she took his pillowcase to the laundry.

Later that afternoon, the aide returned to Mr. Cooper's bedroom and found him lying in bed. The aide called to Mr. Cooper, but he was unresponsive. The aide then called to the administrator for assistance. According to the incident report completed by the administrator of Brentwood Adult Home, she ran to Mr. Cooper's bedroom, which was on the second floor, and also contacted an ambulance. The maintenance man also entered Mr. Cooper's bedroom in response to the aide's call for assistance.

Based on information obtained from the staff of Brentwood Adult Home, after the administrator entered Mr. Cooper's bedroom, the aide and maintenance person left the room, leaving the administrator in charge. The home's staff also reported that they did not administer cardiopulmonary resuscitation (CPR) or any other emergency medical procedures.

The home's staff also reported that they did not administer cardiopulmonary resuscitation (CPR) or any other emergency medical procedures.

At 2:47 p.m., the ambulance arrived and the emergency medical technicians began CPR. Mr. Cooper did not respond to treatment, and he was transferred to Southside Hospital in cardiac arrest. Mr. Cooper arrived at Southside Hospital's Emergency Room at 3:08 p.m. in full cardiorespiratory arrest, and he was pronounced dead ten minutes later at 3:18 p.m.

Subsequent to Mr. Cooper's death, on October 25, 1991, his case manager from Catholic

Charities Community Support Services closed Mr. Cooper's case with the following summary note:

> *Nicholas' life in a community setting was brief. He had difficulty in taking care of his own needs and unfortunately did not receive the assistance he needed in this area on a consistent basis... The circumstances surrounding his death and hospitalizations have been reported to DAS [DSS's Division of Adult Services] and Quality Assurance. The state department will take care of burial arrangements but require a 30 day wait to allow for family contact.*

Based on recollections of Brentwood Adult Home staff and the home's record, Pilgrim Psychiatric Center staff had made no other contact with Mr. Cooper since his discharge to the home three months earlier.

Funeral services for Mr. Cooper were conducted on November 4, 1991. Fees for Mr. Cooper's wake and burial services were paid by a local Catholic Church and Medicaid. Mr. Cooper's case manager from Catholic Charities Community Support Services and staff of Pilgrim Psychiatric Center who had worked with Mr. Cooper during his hospitalization attended the service. Based on recollections of Brentwood Adult Home staff and the home's record, Pilgrim Psychiatric Center staff had made no other contact with Mr. Cooper since his discharge to the home three months earlier.

Postmortem Review

An autopsy report revealed that the cause of Mr. Cooper's death was cardiac tamponade due to ruptured myocardial infarct and arteriosclerotic heart disease.

Subsequent to Mr. Cooper's death, physicians from the Commission's Medical Review Board reviewed Mr. Cooper's record and autopsy report and concurred with the cause of death documented on the autopsy report. The physicians also agreed that the falls Mr. Cooper sustained and the complaints (e.g., lower back pain) he reported during the week prior to this death were not warning signs of this medical condition. Reportedly, Mr. Cooper's cause of death was a rupture of the heart vessel, causing an accumulation of blood in the cardial sac surrounding the heart. According to the Medical Review Board, this condition occurs infrequently after an individual suffers a heart attack.

The Medical Review Board's review did raise several concerns and questions regarding Pilgrim Psychiatric Center's decision to discharge Mr. Cooper, and the ability of the Brentwood Adult Home to provide appropriate care and treatment, and the appropriateness of the medical care rendered by Southside Hospital. Specifically, the Board found the following:

- no documentation in Mr. Cooper's Pilgrim Psychiatric Center record indicating his readiness for discharge to an adult home;
- problems in the appropriate care, and in personal care services for Mr. Cooper by the Brentwood Adult Home, as well as errors in the home's management of Mr. Cooper's medications also raised questions about the quality of the Brentwood Adult Home's operations;
- problems in the Department of Social Services' regulatory oversight of the Brentwood Adult Home, as it appeared that the home was not providing an adequate standard of care; and
- the failure of Southside Hospital during Mr. Cooper's second visit to the hospital's emergency room (October 9, 1991) to

remove his sutures and fully explore the cause of his abnormal lab values.

In addition, the physicians questioned why the staff of Southside Hospital's Emergency Room did not follow up on Mr. Cooper's poor hygiene noted during his September 25, 1991 and October 9, 1991 visits.

Upon review of the Commission's draft report, on June 21, 1993 the President of Southside Hospital submitted a letter to the Commission which stated:

> *We take strong exception to the conclusions drawn relative to the treatment provided at Southside Hospital . . . the role of the emergency department is to provide emergency care . . . the standard of care for hospital emergency departments is not to routinely remove sutures unless they are infected or pose a medical emergency to the patient . . . it is unrealistic to expect that an emergency department staff should follow-up poor hygiene [sic] when the patient's poor hygiene did not adversely affect their medical condition . . . it is not within the purview of an emergency department to take a primary role in changing an individual's lifestyle, even though that lifestyle may be perceived as being detrimental.*

Chapter III
Serina Williams

Ms. Williams was born in Puerto Rico on October 15, 1932 and lived with her parents and younger brother until age four when Ms. Williams' father died of tuberculosis. Little is known about Ms. Williams' early childhood. According to record notes, Ms. Williams attended school in Puerto Rico, but by age 13, she had only completed the fourth or fifth grade.

In 1946, at the age of 13, Ms. Williams and her family moved to New York City where she enrolled in the public school system and was placed in special classes at a vocational and trade school. Record notes indicated that one year later, Ms. Williams was referred to the Bureau of Child Guidance due to poor attendance and achievement. The psychological assessment revealed that Ms. Williams had an IQ of 65 and was sufficiently retarded to be eligible for special placement.

Brief Foster Care Placement

Approximately three years later, at the age of 16, Ms. Williams was referred for placement in the Department of Welfare's Division of Foster Care. This referral was made because Ms. Williams' mother required medical hospitalization for treatment of tuberculosis, and there were no other family members to care for her. Record notes indicated that upon admission to the program, Ms. Williams was placed at the Department's Welfare Shelter.

Four months later, in February 1949, Ms. Williams was referred to the Department of Mental Hygiene for evaluation and placement. Record notes indicated that Ms. Williams required institutional care because she would not be able to "adjust in a foster home due to her inadequacies." Ms. Williams was evaluated at Bellevue Hospital, and on March 23, 1949, she was transferred to Letchworth Village State School, which serves persons with mental retardation. This admission to Letchworth marked Ms. Williams' first involvement in the state's mental hygiene system (Figure 9).

Early Years of Institutionalization (1949-1971)

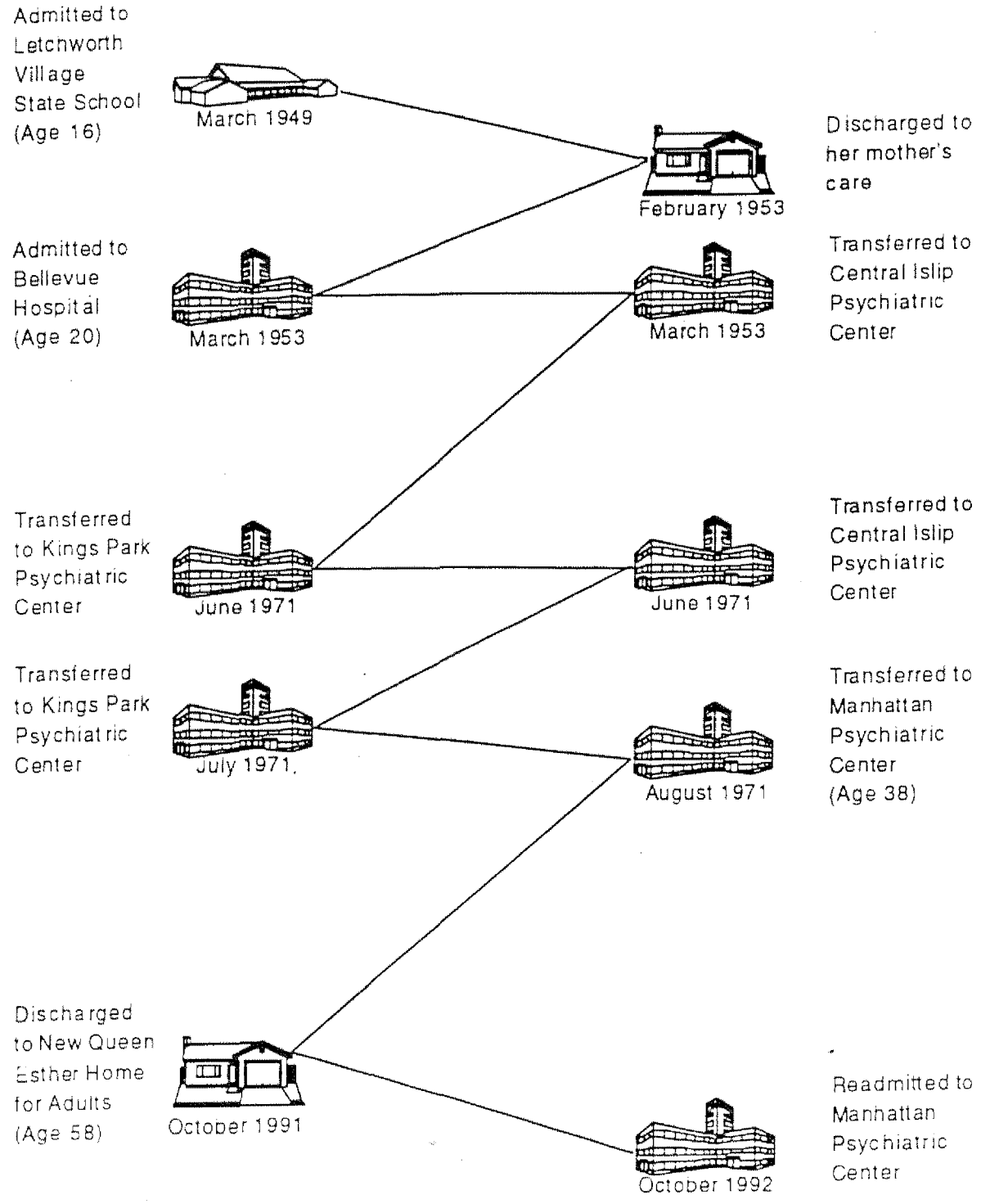
Clinical records indicated that upon admission to Letchworth, Ms. Williams was quiet, polite, and friendly, and she was able to read and to provide the physician with a summary of her childhood. One week after admission to Letchworth, a psychological examination revealed that Ms. Williams had a mental age of 7 years, 3 months and an IQ of 48.[10] The psychological examination report also stated that Ms. Williams had a "Spanish language handicap."[11]

Approximately three years after her admission to Letchworth, progress notes indicated that Ms. Williams was experiencing a personality change and "psychotic symptoms including

[10] There are four subtypes of mental retardation reflecting the degree of intellectual impairment. An IQ score between 50 and 70 indicates a level of mild mental retardation, and a score between 35 and 49 indicates a level of moderate mental retardation.

[11] Ms. Williams' record did not indicate whether the psychological evaluation was conducted in English or Spanish.

Figure 9: Significant Events in Ms. Williams' Life 1949-1992



preoccupation, withdrawal, physical and mental retardation, seclusiveness, and affective deterioration." Record notes also indicated that Ms. Williams began experiencing auditory hallucinations and that her speech was becoming somewhat incoherent.

Nearly four years after her admission, in February 1953, the Department of Mental Hygiene recommended that Ms. Williams be transferred to Pilgrim Psychiatric Center for further treatment; however, her mother refused to sign the commitment petition, and, on February 22, 1953, Ms. Williams was discharged to her mother's home. The discharge summary indicated that Ms. Williams' discharge was "against the advice of institution authorities."

Clinical records indicated that upon admission to Manhattan Psychiatric Center, Ms. Williams was "mute, seclusive, withdrawn, and noncompliant with instructions given to her."

On March 2, 1953, eight days after her discharge from Letchworth, Ms. Williams was admitted to Bellevue Hospital for "hearing voices." One week after admission, Ms. Williams, at the age of 20, was transferred to Central Islip Psychiatric Center where she lived for the next 18 years of her life. According to clinical records, upon admission Ms. Williams was restless, somewhat upset, and mute during most of the admission interview. During this hospitalization, Ms. Williams received psychotropic medications and ECT treatments.

On June 3, 1971, Ms. Williams was transferred to Kings Park Psychiatric Center for "administrative reasons." Three weeks after her transfer, record notes indicated that Ms. Williams had fallen and sustained a head injury, after which she had a brief loss of consciousness and seizures. The following day, Ms. Williams was transferred in a comatose condition to Central Islip Psychiatric Center's Medical Surgical Building. Approximately three weeks later, on July 15, 1971, record notes indicated that Ms. Williams had completely recovered and was returned to Kings Park Psychiatric Center. On August 16, 1971, Ms. Williams was transferred to Manhattan Psychiatric Center, where she lived for the next 20 years of her life.

Twenty Years at Manhattan Psychiatric Center (1971-1991)

Clinical records indicated that upon admission to Manhattan Psychiatric Center, Ms. Williams was "mute, seclusive, withdrawn, and noncompliant with instructions given to her." She was also noted as being "childish, regressed, and confused and in a catatonic like state."

Over the next 20 years, clinical assessments indicated that Ms. Williams continued to be withdrawn, and she was unable to participate in most ward activities due to her inability to communicate and her impaired reality orientation. Her records for this period also documented no appreciable improvement in her psychiatric condition and indicated that she did not interact with other patients or staff. Record notes also indicated that Ms. Williams spent her days sitting in the dayroom sleeping, watching other patients, staring out the window, gazing around, pacing the ward, and peeking through keyholes.

Ms. Williams' record provides no documentation indicating that the clinical staff made any referrals for psychological testing to determine the possible cause of Ms. Williams' adaptive behavior deficits or her degree of intellectual impairment until December 1990, when she was reportedly tested using the Vineland Social Maturity Scale, in contemplation of her possible transfer to the center's dually diagnosed unit. The psychologist's report of this testing was never filed in Ms. Williams' record, although a brief note indicated that she performed as a 12

year old. For unknown reasons, Ms. Williams was also not referred to the center's dually diagnosed unit.[12] There was also no documentation that the facility made any referrals for Ms. Williams to a mental retardation facility, which may have been better able to meet her needs.

In January 1991, the treatment team conducted a periodic treatment plan review to discuss Ms. Williams' progress and the goals of her treatment plan. The minutes of this review stated, "[Ms. Williams] continues to be isolated . . . and is still not able to attend more than 10 hours of programing per week," but went on to state that Ms. Williams "would benefit from living outside of the hospital in a supervised adult home, as she was probably as stable as she can get in the hospital." The note concluded that Ms. Williams' discharge plan was reviewed and remained the same.

Although there were fleeting references to some progress in Ms. Williams' condition dated March 14, 1991, May 22, 1991, and June 24, 1991, the vast majority of progress notes in her record for the nine-month period (January-October) prior to her discharge indicated little change. Clinical records indicated that Ms. Williams was not profiting from leisure education groups because she had no contact with reality and did not understand what was going on.

Progress notes also indicated that Ms. Williams spent most of her time staring out the window, sitting in a corner observing people, or just looking out into the distance.

Progress notes also indicated that Ms. Williams spent most of her time staring out the window, sitting in a corner observing people, or just looking out into the distance.

Despite the little improvement documented in her record, on July 2, 1991, Ms. Williams' treatment team met again and concluded that Ms. Williams should be discharged to an adult home.

Despite the little improvement documented in her record, on July 2, 1991, Ms. Williams' treatment team met again and concluded that Ms. Williams should be discharged to an adult home.

Overall, these record notes indicated that Ms. Williams was unable to communicate her needs, to understand what was going on around her, or to participate in ward activities (Figure 10). Also, despite the reference in her January 1991 treatment plan review, Ms. Williams was not referred to visit any adult homes until nearly nine months later.

Ready for Discharge?

Despite the little improvement documented in her record, on July 2, 1991, Ms. Williams' treatment team met again and concluded that Ms. Williams should be discharged to an adult home. But again, no steps were taken to assist Ms. Williams with her readiness for discharge or to refer her to adult homes.

Three months later, on September 20, 1991, the treatment team conducted a comprehensive treatment plan review and agreed that in order to meet discharge criteria, Ms. Williams would have to "become verbal enough to make her needs known . . . by her using words and not gestures." The tentative date for her planned

[12] In April 1993, a psychologist from Manhattan Psychiatric Center did report to the Commission that reports of the Vineland Social Maturity Scale administered to Ms. Williams in December 1990 were found in the Psychology Department Offices of the Center. The psychologist could not explain why this report was not filed in Ms. Williams' record or why no follow-up had been done.

Figure 10: Excerpts From Manhattan's Record Notes: Six Months Prior to Discharge

April 2, 1991 - Periodic Treatment Plan Review

Recreational therapist states that even though Pt. isolates herself most of the time, she does participate in activities, such as going for walks, dancing, listening to music . . . is not able to attend more than 10 hours of scheduled programming.

May 22, 1991 - Rehabilitation Services' Monthly Note

Pt. during the program just sat in the chair and could not verbalize anything. She was only there physically present but her mind was not in the group.

June 19, 1991 - Psychiatrist's Monthly Note

Continues to be withdrawn and seclusive . . . it has been difficult to communicate to her at meaningful level . . . unable to attend 20 hrs. per week.

July 2, 1991 - Periodic Treatment Plan Review

The pt. continues stable . . . pt. is still not able to attend more than 20 hrs. of programming a week.

July 22, 1991 - Rehabilitation Services' Monthly Note

Pt. "physically" attended programs . . . but could not actively join in the performance of which. . . . pt. just sat and "eyed" the participants from the side . . . pt. could not do anything and just sat on [sic] a corner.

August 25, 1991 - Rehabilitation Services' Monthly Note

Failed to attend her exercise and leisure education because up to this time she was not ready for structure-directed group activities . . . pt. was able to make a little progress on reality orientation but her sociability increased from nil to adequate.

September 20, 1991 - Comprehensive Treatment Plan Review

Pt. will become verbal enough to make her needs known . . . by her using words and not gestures . . . She is very withdrawn and isolated and un-communicative [sic]. Attention span is very poor. She is unable to maintain 20 hours of weekly programming. [Patient] needs assistance with activities of daily living skills . . . tentative release/discharge date: 12/16/91.

October 1, 1991 - Social Worker's Progress Note

The pt. continues to do well [on] the ward . . . scheduled for an interview at New Queen Esther Home. They are willing to take her and accept her if she can communicate her needs.

October 1, 1991 - Periodic Treatment Plan Review

Pt. is cooperative and participates within her current capabilities. However, she is limited because of her being non-verbal . . . pt. is not able to participate in 20 hours of scheduled programming a week.

October 19, 1991 - Psychiatric Assessment

It has been difficult to communicate with her at a meaningful level and to identify the thought content. She is mute and thus responds with head motions and sounds that mean yes or no . . . her main strength is how easy she is to have around . . . her long-standing withdrawal and mutism are denote [sic] a severe constriction of cognition and affect.

discharge was set for December 16, 1991. During this meeting, the treatment team also agreed that Ms. Williams was very withdrawn, isolated, and uncommunicative. The team added that she had a very poor attention span, was unable to participate in most programming offered, and required assistance with her activities of daily living.

Despite the clear delineation of Ms. Williams' deficits and lack of readiness for discharge, the treatment team made no recommendations for special interventions or psychological testing to address these concerns. There was also no documentation indicating that the team considered referrals for Ms. Williams to other more supervised residential community programs sponsored by the Office of Mental Retardation and Developmental Disabilities, which may have been more able to meet her needs.

One month later in October 1991, progress notes indicated that it was still difficult to communicate with Ms. Williams at any meaningful level and that her participation in ward activities was passive because she was "out of reality" most of the time. The monthly note for September and October, entered by the unit's direct care staff person responsible for Ms. Williams, stated:

> *Pt. remains mute, isolative. She sits by herself in the dayroom sleeping most of the time. She continues to use facial expressions to answer most questions, it still remains hard to discern whether she fully understands or not... She has to be directed as to what to do, but she carries out functions appropriately.*

Subsequently, nine days prior to Ms. Williams' discharge, on October 19, 1991, an updated psychiatric assessment presented a markedly more positive account of her recent progress documented in her record.[13]

Reviewers found that New Queen Esther Home for Adults had serious problems in all areas reviewed. The home was rated as one of the poorest homes in the Commission's sample.

> *Her course during the past year has been good. As documented well in the therapy aide and nursing monthly progress notes, she has become verbally interactive and taking much better care of her personal hygiene and personal area on the ward ... since March she has been able to attend more than twenty hours of active programming every week... at present her main strength is how easy she is to have around... despite her being mute most of the time, she comes across as a nice, well-meaning person... she is now suitable for adult home placement.*

Consistent with this psychiatric assessment, a social worker's note of October 1, 1991 indicated that Ms. Williams was scheduled for an interview at New Queen Esther Home for Adults, a 47-bed adult home facility located in the Rockaway section of Queens. The social worker's note continued, "[the home is] willing to interview her and accept her if she can communicate her needs."

Of note, New Queen Esther Home for Adults first came to the Commission's attention during the agency's study of adult homes serving a

[13] The October 19, 1991 psychiatric assessment update was completed by the unit's supervising psychiatrist who had been covering for Ms. Williams' regular psychiatrist since July 1991. Record notes indicated that the psychiatrist based his examination on the previous psychiatrist's observations for one year and his daily rounds over the three and a half month period (July-October).

Figure 11: Conditions at New Queen Esther Home for Adults

Commission's Site Visit of October 1989

- Residents complained that their rooms were infested with roaches and that staff steal their clothing, as well as their personal belongings.
- Residents were poorly dressed in dirty, ill-fitting, seasonally inappropriate, and worn clothing; some residents' clothing was wet, soaked with urine.
- For the seven residents who are incontinent of urine and/or feces, staff reported that their clothing is rinsed out in the toilet and only sometimes washed in the machine.
- Resident bedrooms were filthy and had a rancid odor of urine and sweat.
- Some beds had no linens or blankets, and residents had to sleep on top of the plastic-coated mattresses.
- Mattresses . . . were extremely dirty, and some were stained with urine, blood, and food spills.
- Residents spent their day sleeping in bed or in the lounge, sitting in the lounge watching TV or roaming the facility.
- Bathrooms were extremely dirty, with mold-covered ceilings, walls, and fixtures . . . shower curtains were covered with black mold and mildew.
- No food was brought to the [one] resident who was in bed with a virus, nor did any staff prompt this resident to get out of bed and come to lunch.
- Roasts, chickens, and fish fillets [stored in the chest freezer] were discolored and freezer burned . . . the refrigerator fans were also extremely dirty and coated with grease.
- Physician-prescribed medications were found on the residents' bedroom end tables . . . [and] accountability for controlled medications was also not uniformly assured.

preponderance of residents with mental illness.[14] During this study, the Commission conducted unannounced site visits to 47 adult homes across the state, and during an October 1989 site visit, reviewers found that New Queen Esther Home for Adults had serious problems in all areas reviewed. The home was rated as one of the poorest homes in the Commission's sample (Figure 11).[15]

Although in October 1991, at the time of Ms. Williams' interview, New Queen Esther Home for Adults was certified by the State Department

[14] *Adult Homes Serving Residents with Mental Illness: A Study of Conditions, Services, and Regulation,* October 1990.

[15] On October 20, 1989 the Commission submitted a letter of findings to the home's operator and to the Department of Social Services. On several occasions in the fall of 1989, the Commission also discussed the conditions of the home with staff of the Department of Social Services and advocated for appropriate enforcement action. On February 22, 1990, Commission staff conducted a follow-up visit to the home which revealed few improvements. A report of this visit was also submitted to the home's operator and to the Commissioners of the Department of Social Services and the Office of Mental Health.

of Social Services, it had received noncompliance ratings on each of the Department's 14 complete inspections since 1980 (Figure 12).

On October 21, 1991, Ms. Williams was escorted to New Queen Esther Home for Adults by her social worker from Manhattan Psychiatric Center for an interview with staff of the Rockaway Mental Health Services Community Support Systems. The Rockaway Mental Health Services Program, sponsored by the Catholic Charities Brooklyn-Queens Diocese, is responsible for interviewing and screening all individuals with mental illness for appropriate placement in adult homes located in the Rockaway section of Queens. The home's administrator and a staff person of one of the home's on-site mental health teams, Creedmoor Psychiatric Center's Adult Home Clinic Program, also participated in Ms. Williams' interview.

The screening narrative completed by Rockaway Mental Health Services stated:

> *. . . Insight and judgement impaired. Unable to maintain eye contact. Is selectively mute and responds by either shaking head yes or no. It was impossible to obtain any history . . . appears quite institutionalized. Sits in chair and rocks. Worker reports she is independent in ADL [activities of daily living] and cooperates with staff not presenting any management problems. It appears that Ms. Williams would like to live at Queen Esther because she knows a resident at the home. Was calm and cooperative. Smiled frequently . . .*

Although Ms. Williams has a brother who had visited her at Manhattan Psychiatric Center on weekends, there was no documentation that he had been either consulted or informed of Ms. Williams' discharge.

Figure 12: DSS Complete Inspections for New Queen Esther Home for Adults 1980-1991

Year	DSS Rating
1980	Noncompliance
1980	Noncompliance
1981	Noncompliance
1982	Noncompliance
1983	Noncompliance
1985[1]	Noncompliance
1986[2]	Noncompliance
1987[2]	Noncompliance
1988	Noncompliance
1988	Noncompliance
1989	Noncompliance
1990	Noncompliance
1991	Noncompliance
1991	Noncompliance

[1] DSS conducted a complete and a follow-up inspection during the complete inspection visit.

[2] DSS conducted a complete and a complaint inspection during the complete inspection visit.

The screening team concluded the narrative by stating:

> *Home is willing to give her a chance and in view of its small size can provide the necessary supervision. Accepted . . .*

Although Ms. Williams has a brother who had visited her at Manhattan Psychiatric Center on weekends, there was no documentation that he had been either consulted or informed of Ms. Williams' discharge. In a telephone interview with Commission staff on March 18, 1993, Ms. Williams' brother reported that he first learned

After nearly 42 years of institutionalization, Ms. Williams, who was now 59 years old, was discharged from Manhattan Psychiatric Center to New Queen Esther Home for Adults.

of his sister's discharge in January 1992 when he went to visit her at Manhattan Psychiatric Center. He explained that, at that time, he was very upset because no one had called him or sent him a letter informing him of his sister's discharge to an adult care facility.

Ms. Williams' Discharge

On October 28, 1991, the date of Ms. Williams' discharge, the psychiatrist signed Ms. Williams' discharge plan and summarized that she had "improved appreciably to the point that she could be managed outside the hospital . . . [and] had achieved maximum benefit from hospitalization." Thus, after nearly 42 years of institutionalization, Ms. Williams, who was now 59 years old, was discharged from Manhattan Psychiatric Center to New Queen Esther Home for Adults. Upon discharge, her psychiatric diagnosis was schizophrenia, chronic disorganized.

At the time of discharge, Ms. Williams was prescribed Mellaril, 100 mg. twice a day and Sinequan, 50 mg. at the hour of sleep. Ms. Williams received a one-month supply of these medications, an appointment with Creedmoor Psychiatric Center's aftercare psychiatrist (November 2, 1991), and a general referral to the physician who provides medical care to the residents at New Queen Esther Home for Adults.

Ms. Williams was also referred to Creedmoor Psychiatric Center's Adult Home Clinic Program for on-site case management and mental health services.

Prior to discharge, Ms. Williams was screened by the City's Division of Post Institutional Services (DOPIS), which is funded by the NYC Department of Social Services to provide case management and support services to individuals with five or more years of institutionalization upon their discharge to the community. Reportedly, these services were to begin at the time of Ms. Williams' discharge.

Ms. Williams' Move to New Queen Esther Home for Adults

According to interviews with the staff of New Queen Esther Home for Adults and staff of the Creedmoor Psychiatric Center's Adult Home Clinic Program, upon admission, Ms. Williams

Upon admission to New Queen Esther, Ms. Williams could not dress or shower herself, change her clothes, or complete her activities of daily living.

could not dress or shower herself, change her clothes, or complete her activities of daily living. These staff, added that Ms. Williams survived at New Queen Esther, largely because she was the beneficiary of daily personal care from her roommate, Ms. Melissa Murphy.

Ms. Murphy, an independent, high-functioning woman, reportedly cared for Ms. Williams like she was one of her own children. Each morning Ms. Murphy would wake Ms. Williams and assist her in showering and dressing, and then escort her down the elevator to breakfast, as Ms. Williams was unable to operate the elevator herself. At the end of the day, Ms. Murphy would escort Ms. Williams back upstairs and assist her in getting ready for bed and changing into her pajamas.

Adult home staff and staff from the on-site Creedmoor Clinic Program told the Commission that if Ms. Williams' roommate did not prompt her to wake each morning, she would have stayed in bed all day; if not escorted to meals, she would not eat; and if not escorted to her bedroom, she would have stayed all night in the lobby or sitting on the floor in the elevator, not knowing which button to push. A staff person from the on-site Creedmoor Clinic Program also added, that if someone yelled "fire," Ms. Williams would not know what to do, and she would require assistance to evacuate the residence. This same staff person also added that Ms. Williams was unable to read and did not know what medications she was prescribed.

The staff of Manhattan Psychiatric Center had made no contact with Ms. Williams during the year Ms. Williams lived at New Queen Esther.

According to the home's staff, Ms. Williams spent her days at New Queen Esther sitting in the lounge, pacing the floors, and riding the elevator. Staff also reported that while at New Queen Esther, Ms. Williams learned to smoke cigarettes, and she would spend her days "smoking like crazy."

The home's staff and social workers at Manhattan Psychiatric Center, who were involved in Ms. Williams' discharge to New Queen Esther, indicated that the staff of Manhattan Psychiatric Center had made no contact with Ms. Williams during the year Ms. Williams lived at New Queen Esther. Reportedly, two social workers from Manhattan Psychiatric Center saw Ms. Williams at New Queen Esther on two or three occasions when they escorted other patients to visit the home in preparation for their discharge. These were informal contacts, and staff made no formal inquiries about Ms. Williams' progress or well-being. Record notes were also not maintained regarding these informal contacts.

Aside from the above general comments from the adult home staff and the staff of the on-site Creedmoor Clinic Program, the only other insights the Commission could obtain about Ms. Williams' life at New Queen Esther came from the home's communication logbook[16] and staff notes from the Creedmoor Clinic Program.

According to New Queen Esther's March 31, 1992-October 14, 1992 communication logbook,[17] Ms. Williams had several difficulties during this period, especially after June 1992:

Melissa Murphy claims that Serina Williams her roommate gets hurt from somebody here in this home.

- June 27, 1992: *Melissa Murphy claims that Serina Williams her roommate gets hurt from somebody here in this home. Serina has a big black and blue mark on her leg. Melissa Murphy claims its not the first time it has happen [sic]. She claims Serina had blue and black marks before.*

[16] The staff of New Queen Esther Home for Adults utilize the logbook to communicate with staff from shift to shift and to communicate with the staff of the two on-site mental health teams.

[17] Although the Commission requested copies of the communication logbook for the duration of Ms. Williams' residence at New Queen Esther Home for Adults, on April 20, 1993, the operator submitted a letter to the Commission stating, "The shift log records which you requested [October 1, 1991–March 30, 1992] are no longer available."

who lived in the Bronx. Additionally, although other record notes (December 18, 1991, February 13, 1992, April 16, 1992, and July 10, 1992) indicated that the Creedmoor Clinic Program staff were puzzled about Ms. Williams' actual ability to communicate her needs and to understand what was said to her, there were no notes indicating that any professional consultation was sought to assess Ms. Williams' communications skills and deficits. For example, no effort was made to obtain a psychological or speech therapist consultation which may have promoted a better understanding of the origins of Ms. Williams' mutism or suggestions for interventions that may have helped her to communicate more effectively.

There were no explanatory notes indicating how Ms. Williams, who was repeatedly described as mute and noncommunicative, was likely to benefit from the weekly individual therapy sessions.

The treatment team developed three treatment objectives for Ms. Williams:

> *Client will not exhibit bizarre behavior, withdrawn behavior, or appear to be responding to auditory hallucinations in 30-minute [individual therapy] sessions with Creedmoor Clinic Program staff for three months.*
>
> *Client will acknowledge that she has attended on-site activity [i.e., bingo, arts and crafts, grooming, etc.] five times a week to Creedmoor Clinic Program staff for three months.*
>
> *Client will acknowledge that she has showered two times a week and put on clean clothes for three months.*

Ms. Williams' April and July periodic treatment reviews indicated that these treatment objectives were not revised during her first year at New Queen Esther. Despite the emerging problems with Ms. Williams' behavior in the summer of 1992, her treatment objectives were not changed although, as detailed below, her psychotropic medications were periodically changed. Finally, there were no explanatory notes indicating how Ms. Williams, who was repeatedly described as mute and noncommunicative, was likely to benefit from the weekly individual therapy sessions.

Other Creedmoor Clinic Program record notes indicated that the recreation therapist made 25 case management entries for Ms. Williams for the period November 1991—October 1992. These notes usually provided general comments about Ms. Williams' appearance, a few notes regarding her attendance at a group activity (November 22, 1991, December 8, 1991, February 4, 1992, March 18, 1992, and May 15, 1992), and other reports of her behavior.

Three months after her admission to the home (January 16, 1992), a case management note also referenced that Ms. Williams had agreed to go for an interview at an adult day care center which provides recreational activities to older adults in need of medical supervision. The next day, however, another note indicated that Ms. Williams did not want to attend the program. Record notes did not discuss Ms. Williams' change of mind, but staff interviews suggested that no one was quite sure whether Ms. Williams understood either the first or the second inquiry. In any case, she never attended the day program.

Clinic notes referenced her disrobing in public, wandering away from the home into the community, roaming the halls and rooms of the adult home at night, and not sleeping.

Corresponding to the entries in the home's communication logbook, as of June 1992, the Creedmoor Clinic Program's notes also referenced numerous problems Ms. Williams was encountering at the home, as her behavior became more inappropriate. These notes referenced her disrobing in public, wandering away from the home into the community, roaming the halls and rooms of the adult home at night, and not sleeping.

Other notes in the Creedmoor Clinic Program record indicated that in response to these notes and apparently other reports of Ms. Williams' difficulties, the psychiatrist met with Ms. Williams several times (July 6, 10, 13, and 17, 1992) and attempted to address these problems, usually by adjusting her psychotropic medications. For example, on July 10, 1992, Ms. Williams' medication regime was changed to Haldol Decanoate, 50 mg., intramuscularly every week. Record notes indicated that Ms. Williams continued to be agitated and did not sleep and, on July 13, 1992, the psychiatrist added medications to Ms. Williams' medication regime (Haldol, 5 mg. twice a day and Cogentin, 1 mg. once a day). Subsequent notes after this second medication change indicated that Ms. Williams' behavior improved and that, in particular, she was no longer wandering away from the home.

Two months later, on September 15, 1992, Ms. Williams was observed by the Creedmoor Clinic Program's recreation therapist walking in a stiff manner and pacing. The following day the psychiatrist again evaluated Ms. Williams and concluded that she may be developing tardive dyskinesia, an adverse side effect of some psychotropic medications characterized by involuntary, repetitious movements of the muscles of the face, limbs, and trunk. At the conclusion of this examination, the psychiatrist decreased Ms. Williams' Haldol Decanoate to 50 mg. intramuscularly every two weeks and discontinued her daily oral doses of Haldol.

Although there were repeated references to Ms. Williams' communication problems and the difficulties these problems presented in her treatment and in her participation in activities, the clinic staff took no steps to explore these problems further.

These notes suggested that Ms. Williams received regular clinical services from the Creedmoor Clinic Program during her one-year residence at New Queen Esther Home for Adults. These staff appeared to be well-apprised of Ms. Williams' condition, and they took steps, primarily in adjusting her medications, to address her emerging problems as of June 1992. Throughout this time period, however, although there were repeated references to Ms. Williams' communication problems and the difficulties these problems presented in her treatment and in her participation in activities, the Creedmoor Clinic Program staff took no steps to explore these problems further. They did not contact the discharging hospital, Manhattan Psychiatric Center, nor did they inform Ms. Williams' brother.

This oversight was particularly unfortunate as the clinic staff never seemed to have considered that these problems may have a cognitive component and/or an organic origin. After Ms. Williams' return to Manhattan Psychiatric Center in October 1992, the Commission requested that Manhattan assure her a complete psychological assessment, conducted by a staff person familiar with testing individuals with mental retardation. In April 1993, this testing was completed, and it showed that Ms. Williams was mentally retarded and had scored less than 50 on the full scale WAIS (Weschler Adult Intelligence Scale), indicative of moderate mental retardation.

Ms. Williams' Last Two Days in New Queen Esther Home for Adults

On October 11, 1992, direct care staff at New Queen Esther Home for Adults again documented in the communication logbook that Ms. Williams was experiencing problems:

> *Serina is getting real out of hand now at lunch time she push [sic] her finger down Myron's ear and begun ringing [sic] it five minutes later she took the cup from the table and hit Fran in her head. Please do some thing [sic] about her before she hurt [sic] someone seriously.*

This staff person told the Commission that she had contacted the home's operator to explain the problems Ms. Williams was experiencing and that she was abusing other residents. Reportedly, the operator of New Queen Esther asked the staff person to check the medication book to ensure that Ms. Williams had taken her medications. While on the telephone with the operator, this staff person checked the medication administration book which indicated that Ms. Williams had complied with her medication regime. The operator offered no additional assistance. This staff person was relieved at 5:00 p.m. by the evening shift staff person.

That evening, the staff person entered the following note in the communication logbook:

> *Serina pouch [sic] Marianne Burns right in her left eye and made it black and blue it was at dinner time. Something has to be done with her. And after she did it she was laughting [sic] about it.*

In an interview with Commission staff, this staff person reported that she also applied a cold compress to Ms. Burns' eye.

The communication logbook and staff interviews indicated that during lunch the following day, Ms. Williams pushed Ms. Burns, a frail 83-year-old woman, causing her to fall backwards and hit her head on the linoleum floor. Ms. Burns, who had lived at New Queen Esther for approximately 14 years, sustained numerous injuries including a broken arm, broken ribs, intra-cerebral bleeding, and partially collapsed lungs.

Shortly after the incident occurred, Emergency Medical Services was called, and Ms. Burns was transferred to Peninsula General Hospital for medical treatment, where she remained until January 20, 1993 when she died. Upon interview, Ms. Burns' physician reported that Ms. Burns' death was due to the injuries she had sustained at New Queen Esther on October 12, 1992. The district attorney concurred with this assessment, classifying the death as a homicide.

Common living areas, including resident bedrooms, the lobby, and hallways, were dirty and smelled of urine and smoke.

Soon after the incident, Ms. Williams was escorted by the police in handcuffs to Peninsula General Hospital's Emergency Room for a psychiatric evaluation. After examination, Ms. Williams was readmitted to Manhattan Psychiatric Center.

Upon readmission to Manhattan Psychiatric Center, neither the staff of the Center, nor the staff of the adult home or Creedmoor Clinic Program informed Ms. Williams' brother. Ms. Williams' brother reported to the Commission that in December he went to visit his sister at New Queen Esther and was informed by the staff person on duty that Ms. Williams had been transferred back to Manhattan Psychiatric Center.

Commission's Investigation

On March 9 and 10, 1993, as part of the Commission's investigation of the death of Ms. Burns, Commission staff conducted an unannounced site visit to New Queen Esther Home for Adults. This visit revealed serious problems in the home.

Common living areas, including resident bedrooms, the lobby, and hallways, were dirty and smelled of urine and smoke. The majority of residents were poorly groomed and dressed, and one resident's pants were soaked with urine. Some residents were not wearing shoes and walked around the home wearing filthy socks. Three-foot-high piles of dirty clothing cluttered the dirty laundry room, which also had an overpowering odor of urine and mildew.

Less than half of the home's residents were attending off-site programs, leaving the majority of the residents at home all day. These residents spent their days sitting in their bedrooms,

The Commission found that the staff person in charge was on her first day of the job, and her only previous adult home work experience had been as a cook at another adult home, which had recently been closed by the Department of Social Services due to very poor conditions.

lying in bed sleeping, roaming the hallways and living areas, and sitting idly in the lobby or on the front porch. In short, the Commission's observations indicated that conditions at the New Queen Esther Home had not changed since the Commission's fall 1989 review, which found its conditions to be among the poorest of adult homes sampled across the state.

The Commission's investigation did not confirm the initial allegation that there were no home staff available at the time of the incident, but it did confirm that staff supervision of resi-

One police officer stated that when he arrived at New Queen Esther, "No one seemed qualified."

dents was inadequate. The Commission found that, at the time of the incident, five home staff were on duty, but that the staff person in charge was on her first day of the job, and her only previous adult home work experience had been as a cook at another adult home, which had recently been closed by the Department of Social Services due to very poor conditions. The four other staff persons present were assigned to meal preparation and maintenance activities, and they spoke only Polish and understood little or no English. These staff also reportedly had no direct responsibilities for supervising residents.

Police officers who responded to the incident, as well as the one staff person of the on-site New Hope Guild Centers' program who was also on the scene, reported to the Commission that there appeared to be no adult home staff person in charge and that the scene was chaotic. During an interview with Commission staff, one police officer stated that when he arrived at New Queen Esther, "No one seemed qualified," and he added that it appeared that the staff person on duty could not handle the situation.

The Commission's investigation also indicated that when Ms. Williams began exhibiting assaultive behaviors on October 11, 1992, the day before her fatal assault on Ms. Burns, residence staff did not secure appropriate psychiatric crisis services or evaluation.

Figure 13: Excerpts From the New Queen Esther Logbook September 29–October 12, 1992[1]

- September 29, 1992: *Sarah Schwartz is not feeling well. I gave her medication, but she refused supper, and she is sleeping in the lobby in a very deep sleep. I asked if she wants [sic] to go to the hospital but she said no.*
- September 29, 1992: *Cathy Forester was smoking in her room, like most residents do at times.*
- September 29, 1992: *Keith Nelson was smoking in his room and in the lobby.*
- September 30, 1992: *The doctor came to see Cathy Forester. Cathy was totally out of control threatening to kill her husband and almost kicking and hitting other staff.*
- September 30, 1992: *Cathy was admitted to Creedmoor [Psychiatric Center] today.*
- October 1, 1992: *Irene Landis has a very nasty attiuted [sic] she theatening [sic] me this morning and called me a bitch someone speak to her because I don't like it and she was wrong please talk to her. All I did was knocked [sic] on the door and told her the man want's [sic] her down for bloodtest.*
- October 1, 1992: *Sam Cordon finally promised to have his chest x-ray taken today. When Lisa [adult home staff person] and Kevin, his aftercare worker tried to accompany him to the hospital, Sam took off down the street. We are looking for him.*
- October 3, 1992: *When I came in today Heidi [adult home staff person] told me last night the heat was all the way up. All the resident [sic] were all comples [sic] about the heat. Guy [adult home staff person] left with the key. Heidi had to break the lock when she came in and Jim [home's maintenance person] fixes [sic] the lock.*
- October 4, 1992: *Irene Landis was very nasty and treathed [sic] to hit Pamela the Health aid for Sarah Schwartz.*
- October 6, 1992: *Sean Cartwright smells terrible because he urinates on his clothes, he is also very nerveous [sic] and walks and smokes all night long. he should be hospitalized.*
- October 6, 1992: *Jennifer Sanders was walking around with the most filthy clothe [sic] I ever saw she has a pajama bottom full of coffee stains, and she also went to the bathroom with her clothes on, she is really a problem she should be hospitalized.*
- October 6, 1992: *Sean Cartwright was up mostly all night. And when he wake up he was ringing wet. And smell [sic] terrible.*
- October 8, 1992: *Sean Cartwright smells terrible again. Please SOMEBODY DO SOMETHING ABOUT HIM!!*
- October 9, 1992: *Conrad Smith, the new resident, does not want to follow the rules of the house, he smokes in his room and in the lobby all the time. He also walks around barefooted and with no shirt on.*
- October 12, 1992: *The bathroom by 104 there was a lot of blood on the floor. Raymond see [sic] it and show it to me. I do knew [sic] if it is Larry or the men [sic] in room 105, Gary.*

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[1] All names have been changed to protect each individual's confidentiality.

Life for Other Residents at New Queen Esther Home for Adults

Further review of the New Queen Esther logbook for the six months prior to the incidents between Ms. Burns and Ms. Williams clarified that daily life at the home was characterized by many problems and serious incidents. As detailed in Figure 13, a sampling of these logbook entries just for the two weeks immediately prior to these incidents indicated that residents engaging in difficult and/or dangerous behaviors were hardly exceptional events at this adult home. Home staff frequently entered notes that residents were in need of medical or mental health services, sometimes adding a pleading note, "Please somebody, do something . . ."

Subsequent to the October 1992 incident, the Department of Social Services also conducted a complete inspection of the home which cited violations and concluded:

> *The violations cited in this report are extensive, serious, and indicate a total lack of regard for the regulatory process, and more importantly, resident well-being and rights. We strongly recommend denial of the operating certificate at this time.*[18]

The Department's report also identified 34% of the 47 residents in the home as needing alternative placements to meet their medical and mental health needs (Figure 14).

In response to the seriousness of the Department's report and the Commission's concerns, the NYS Office of Mental Health (OMH) conducted an unannounced review of New Queen Esther. In March 1993, and based on its findings, the OMH suspended patient referrals to the home from state psychiatric centers.

Figure 14: Conditions at New Queen Esther Home for Adults

Department of Social Services' Report of January 1993[1]

- The operator did not provide, through its employees . . . an organized, twenty-four-hour-a-day program of supervision, care, and services.
- The operator has admitted and retained at least fourteen residents who require services beyond those the operator is allowed to provide in an adult home.
- Resident rights were frequently violated . . . residents were subjected to physical and verbal abuse by other residents on an ongoing basis.
- The operator failed to take the appropriate action following a resident's illness or injury.
- The operator failed to maintain the facility in a good state of sanitation . . . [and] in a good state of repair. . . On all three floors of the facility, inspectors detected a strong urine odor.
- All areas of the facility were not free of vermin and rodents . . . Roaches were observed in Room 201 and in the dining room.
- Three areas of mold were growing on the ceiling [of the walk-in refrigerator], and cobwebs between the wall and pipe that runs along the right wall . . . [and] the wire storage shelves are rusting.
- The operator did not conduct an initial program of orientation and inservice training for employees.
- The operator did not maintain an organized and diversified program of individual and group activities.

[1] The DSS's complete inspection was conducted in November 1992.

[18] The New Queen Esther's operating certificate which was issued on January 1, 1989, expired on December 31, 1992.

In short, reviews by the Commission, the Department of Social Services, and the Office of Mental Health, in the fall of 1992 and the spring of 1993, indicated that the poor conditions and services at New Queen Esther initially documented by the Commission in October 1989 had not changed in the ensuing three years. Indeed, the Department's complete inspections of the home over this interval consistently resulted in noncompliance ratings.

Yet, despite these observations—most of which were readily apparent to any visitor to the home—New Queen Esther Home for Adults continued to be certified by the Department of Social Services and, up until March 1993, state psychiatric centers continued to be authorized to discharge their patients to the home. As a result, individuals, even as impaired as Ms. Williams, were regularly admitted to New Queen Esther Home for Adults, although its quality and level of care were seriously inadequate.

Four months after the release of the Department's January 1993 Report of Findings, the Department conducted a complete follow-up inspection of the home which cited 128 serious violations requiring immediate correction. The report concluded:

> *The owner and administrator of this facility just does not get it. The regulations are not being complied with and both do not seem to understand why dispite [sic] numerous explanations given. It is not expected that violations will be corrected quickly . . .*

The Department's report was issued to the home on June 2, 1993 and indicated that the home was referred to the Department's Central Office with a recommendation for enforcement action.

One week later, on June 9, 1993, the Department of Social Services submitted a letter to the operator of New Queen Esther denying renewal of the home's operating certificate. The DSS's letter concluded:

> *The inspection reports issued . . . have confirmed a persistent and pervasive lack of resident care and compliance with Department regulations. In particular, you have failed to provide adequate: case management services, medication supervision, maintenance of building and furnishings, staffing, administration, fire/safety protections and procedures, supervision of residents; staff training, resident admission and retention procedures, sanitation, access by Department staff to facility records and residents, facility record keeping procedures, protection of resident rights, resident personal care services, and food services.*

On June 23, 1993, staff of the Department of Social Services reported that the Department is drafting a Statement of Charges against New Queen Esther Home for Adults. Upon approval from the Department's Legal Division, a fair hearing will be scheduled concerning the charges and the denial of the operating certificate. This process could take months to conclude. Meanwhile, the residents continue to endure substandard conditions.

Chapter IV
Conclusions and Recommendations

Nicholas Cooper and Serina Williams are poignant case examples of New York State's difficulties in transitioning from a largely institutionally based mental health care system to one where most individuals with serious mental illness will be treated in the community. Most mental health professionals and advocates would agree that, in theory, community-based services are better for persons with mental health problems. They can provide more freedom, more opportunities to obtain daily living and vocational skills, and most critically, more opportunities for individuals to enjoy a normal adult life, with fewer restrictions on their civil liberties.

After decades of hospitalization, Mr. Cooper and Ms. Williams were abruptly discharged in 1991, despite years of clinical observations which had, up to then, precluded their release.

The transition to community services for persons who are seriously mentally ill, however, has not gone smoothly in most states, as the challenges of ensuring appropriate discharge decision-making and planning, of creating adequate and appropriate community residential and outpatient services, and of ensuring an adequate safety net for persons long accustomed to the dependency of the institutional asylum have been difficult to surmount. The lives of Mr. Cooper and Ms. Williams well illustrate these challenges.

Appropriateness of Discharge Decisions

After decades of hospitalization, Mr. Cooper and Ms. Williams were abruptly discharged in 1991, despite years of clinical observations of regressed and psychotic symptomatology, and behavioral difficulties which had, up to then, precluded their release. Mr. Cooper—after more than 30 years of institutionalization marked by delusional thinking and an inability to care for himself—was discharged a mere eight days after his treatment team last noted that he did not meet discharge criteria.

One and a half months prior to Ms. Williams' discharge from over 40 years of institutionalization—during which she remained mute, regressed, and unable to care for herself independently—her treatment team opined that she should not be released until she could verbalize her needs; yet, six weeks later she was discharged, still unable to speak and care for herself independently.

Reports indicated that the specific homes to which Mr. Cooper and Ms. Williams were discharged had long-term and serious difficulties complying with the basic custodial regulatory obligations of adult homes.

Appropriateness of Adult Home Placements

Both were placed in adult homes, facilities certified by the Department of Social Services. Although such facilities, by law and design, are not staffed to provide clinical services to their clientele, certification and inspection reports indicated that the specific homes to which Mr. Cooper and Ms. Williams were discharged had long-term and serious difficulties complying with the most basic custodial regulatory obligations of adult homes to provide residents with safe shelter, meals, adequate supervision, leisure activities, medication management, and some assistance in daily living.

Neither Mr. Cooper nor Ms. Williams was visited and assessed by staff of the state psychiatric centers where they had each lived for more than 20 years.

Specific documented problems in the homes included filthy and malodorous rooms, violation of residents' rights, serious problems with the management of medications to residents, fire and safety hazards, and inadequate and inappropriate staff. Despite these gross deficiencies and their long-term failure to comply with regulatory standards, these homes continued to be recertified by the Department of Social Services. Armed with the false assurances communicated by this certification, the discharge planning staff of the state psychiatric centers serving Mr. Cooper and Ms. Williams felt authorized to continue to discharge their patients to the homes.

No Follow Through After Discharge

Section 29.15 of Mental Hygiene Law explicitly states that the discharge of patients shall be in accordance with a written plan which:

- specifies the individual's need for supervision, medication, aftercare services, and vocational assistance; and
- includes a specific recommendation of the type of residence in which the patient is to live and a listing of the organizations, facilities, and individuals available to provide services in accord with the identified needs of the patient.

The law further requires psychiatric center directors in collaboration with, when appropriate, other local government officials, to prepare, implement, and monitor a comprehensive program to:

- determine whether the residence to which a patient has been discharged is adequate and appropriate to his needs;
- verify that the discharged patient is receiving the services specified in the written discharge plan; and
- recommend and take steps to assure the provision of any additional needed services (MHL §29.15 subd. [h]).

The plain language of this provision of the Mental Hygiene Law seems to clearly contemplate that, as part of this "comprehesive program," there be some type of evaluation of the discharge plan as implemented to determine if other actions are necessary to meet the needs of the dscharged patient.

Notwithstanding this directive, however, neither Mr. Cooper nor Ms. Williams was visited and assessed by staff of the state psychiatric centers where they had each lived for more than 20 years. Their post-discharge care was delegated, unchecked, to a variety of community-based medical, social services, and outpatient mental health care providers, who rarely communicated with each other and who had little knowledge of Mr. Cooper's and Ms. Williams' histories and even less knowledge of each other's services to these individuals.

Within three months of discharge, Mr. Cooper died. During his brief out-of-institution experience he resided in an adult home that had received noncompliance ratings from the Department of Social Services on complete inspections for ten years and from which he did not receive adequate personal care and supervision. His mental health case manager did not assure linkage with structured day programs or recreational activities in which he expressed an interest, and medical issues—such as an elevated white blood cell count and the need for the removal of sutures—were known to one provider, but not to others and were not appropriately addressed.

Even though Mr. Cooper's unkempt and dirty appearance was noted by all the professional service providers who saw him, only one took action, his mental health case manager. She complained about the adult home's negligence of Mr. Cooper's basic needs, sparking an investigation by the Department of Social Services, which was delayed for several weeks and which consisted only of interviews with adult home staff and no other professional providers. The Department unfounded the complaint; other professionals continued to note Mr. Cooper's neglected hygienic state; and the case manager, who filed the complaint, was instructed by adult home staff to call before she visited Mr. Cooper, so the home could make sure he was bathed. She never had a chance to do so, as Mr. Cooper died approximately two weeks later.

The case manager, who filed the complaint, was instructed by adult home staff to call before she visited Mr. Cooper, so the home could make sure he was bathed. She never had a chance to do so, as Mr. Cooper died approximately two weeks later.

Ms. Williams' out-of-institution experience lasted almost a year. During that year she remained mute and regressed to the point that she would not or could not get dressed, leave her bedroom or report to breakfast, unless verbally and physically prompted to do so by someone else, usually her roommate.

Ms. Williams spent most of her time idle, surrounded by residents who frequently acted out, at times violently. Ms. Williams, on occasion, was reportedly found bruised, but she could not report the injuries or their origins.

During the year, Ms. Williams spent most of her time idle, surrounded by residents who frequently acted out, at times violently. Ms. Williams, on occasion, was reportedly found bruised, but she could not report the injuries or their origins. And when she, herself, started acting out, and adult home staff wrote "Do something about her before she hurt [sic] someone seriously," home staff failed to secure an evaluation. Notably, this 47-bed home was served by two separate on-site mental health programs, neither of which apparently noticed or intervened effectively to respond to her progressively deteriorating mental condition. The next day, Ms. Williams assaulted a fellow resident, causing her death. She was removed from the home and returned to a state psychiatric center.

Soon thereafter, the Department of Social Services determined that the placement of more than one-third of the home's residents was clinically inappropriate, as they required a higher level of care than provided by an adult home. These residents were being treated by staff of two mental health outpatient programs, located on-site at the home, who admitted having little

or no knowledge of the Department's regulations governing adult homes—an admission which calls into question their ability to serve their clients and advocate for their rights and well-being, but which was also proffered to justify their failure to report the inappropriately placed individuals and other obviously poor conditions in the home.

New York State's mental health policy has prompted the most dramatic census reduction in state psychiatric centers since the early 1970's, but has failed to secure an adequate safety net in the community.

Why Things Fell Apart

The experiences of Mr. Cooper and Ms. Williams were directly shaped by a number of individual failures—precipitous discharges by state psychiatric center staff, placements in chronically substandard facilities, lack of follow-up by discharging psychiatric centers, inadequate services and coordination of such by community-based health, social services and mental health providers, etc.

These failures, however, are rooted in a more fundamental problem: New York State's mental health policy which has prompted the most dramatic census reduction in state psychiatric centers since the early 1970's, but has failed to secure an adequate safety net in the community for individuals who have for years depended on their asylum.

One decade ago, nearly 22,000 patients resided in state psychiatric centers; today there are fewer than 11,000 patients. This census reduction was greatly accelerated in recent years as a result of budgetary pressures. More than 60% of the decade's census rundown occurred within the past five years (Figure 15).

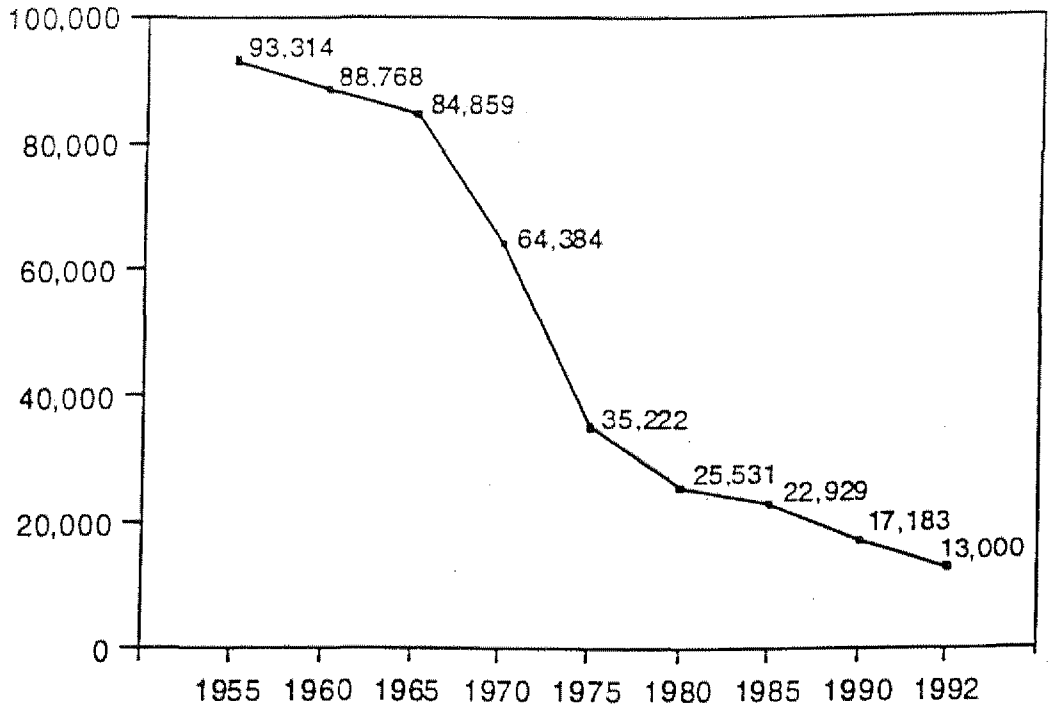
Coterminous with this census decline, OMH officials report that expenditures for mental health outpatient services (exclusive of residential services) have also grown markedly from approximately $745 million in 1986 to almost $1.1 billion in 1991. In proceeding quickly with reducing the census of state institutions, however, this 42% increase in outpatient expenditures has been made largely by continuing to invest in traditional clinical programs, not well-tailored to provide daily assistance or psychiatric rehabilitative services to persons who, like Mr. Cooper and Ms. Williams, have severe functional deficits.

Meanwhile, expenditures for the state's Community Support Services' program, designed to serve persons with serious mental illness and funded entirely with state dollars, have also increased to over $80 million in 1992, but performance expectations for these programs remain largely unarticulated or unmonitored by the Office of Mental Health.[19] Most of these programs, which operate under local assistance purchase of service contracts, are also not certified by the Office of Mental Health.

The mental health outpatient service system remains a fragmented array of independent providers, none of which are accountable for the well-being of individual psychiatric patients who are discharged from state centers or community hospitals.

[19] *In the Matter of the Jacob Home: An Uncertified Adult Home Serving Residents with Mental Illness*, NYS Commission on Quality of Care, August 1991.

Figure 15: Patient Census Change in State Psychiatric Centers (1955-1992)



Most critically, New York's system of community mental health services, with its vast number of providers (approximately 1,000 programs), is not well-coordinated with the state's psychiatric centers or the psychiatric units of community hospitals, which together discharge over 95,000 psychiatric patients annually to the state's communities. Instead, the mental health outpatient service system remains a fragmented array of independent providers, none of which are accountable for the well-being of individual psychiatric patients who are discharged from either state centers or psychiatric units of community hospitals.

With few exceptions, in most counties, individual mental health outpatient providers act as independent agents, and communication and coordination, when they do exist, are the by-products of individual efforts rather than any ordered approach to aftercare services for persons with serious mental illness. Simultaneously, state psychiatric centers, are critically dependent on an assortment of community providers over which they have little influence and no control.

Also, and plainly another by-product of the budgetary constraints of recent years, state funding for the development of new supportive and supervised residential programs, capable of providing a coordinated program of psychiatric rehabilitative services for persons with serious mental illness discharged from state psychiatric centers and community hospitals, has slowed. Thus, in discharging patients, state centers and community hospitals have become increasingly reliant on the least intensive level of care—a

loosely knit patchwork of adult homes and community medical, social services, and mental health providers which have few organizational linkages, standard patterns of communication, or understanding of each other's roles.

Individuals, like Mr. Cooper and Ms. Williams, will most likely find their way to adult homes with such serious deficiencies that their only likely clientele includes very vulnerable men and women of few resources and little capacity or opportunity to make informed choices.

In the best of adult homes, operators, with some justification, complain that their funding (approximately $25–26/day) is insufficient to provide adequately for individuals who are as dependent and impaired as Mr. Cooper or Ms. Williams. Most commonly, however, persons with serious mental illness, long histories of institutionalization, and serious functional impairments, like Mr. Cooper and Ms. Williams, do not find their way to the best adult homes, whose operators usually will not accept individuals whose needs are so clearly beyond their ability to meet.

Instead, these individuals will most likely find their way to adult homes with very poor records of performance and such serious deficiencies in care that their only likely clientele includes very vulnerable men and women of few resources and little capacity or opportunity to make informed choices.

Few Excuses

The directors at Pilgrim and Manhattan Psychiatric Centers both acknowledged that in the past five years making their census targets—which were closely tied to their staffing allocations—was increasingly a lead management priority, creating strong pressure to discharge patients whose clinical needs no longer warranted inpatient psychiatric hospitalization. Both also assailed the "fragmented array of community services" on which they were critically dependent.

Neither was surprised that the Commission found no documentation of their staff's follow-up, despite the decades of Mr. Cooper's and Ms. Williams' institutional stays. Both explained that their follow-up responsibility ends as soon as the patient makes initial contact with the community mental health provider, and they seemed honestly surprised at the Commission's expectation that their monitoring would be more substantial.

These psychiatric center directors consistently explained that any more substantial follow-up had been delegated to the "lead" community mental health outpatient provider. Although neither director could provide a formal written agreement outlining this delegation of follow-up responsibility, the mental health outpatient providers caring for both Mr. Cooper and Ms. Williams seemed apprised of their lead follow-up role, yet they too defined their follow-up responsibility narrowly.

Thus, the central purpose of the discharge planning law—to assure that patients' needs are met adequately and appropriately in the community—seemed to be no one's responsibility in practice.

These community mental health providers recognized their responsibility to ensure that individuals, like Mr. Cooper and Ms. Williams, attended clinic appointments, but they were considerably less likely to take action when other problems—more central to the discharged individual's place of residence and daily life—surfaced. Thus, the central purpose of the dis-

As the Commission reviewed the care of Mr. Cooper and Ms. Williams, it often came to be that our understanding of what the law contemplates should have happened was not shared by the staff of the two state psychiatric centers or the many community providers we interviewed.

charge planning law—to assure that patients' needs are met adequately and appropriately in the community—seemed to be no one's responsibility in practice.

Just why these providers failed to act is not clear. On the one hand, it does not seem possible that they did not "see" the problems as they evolved for Mr. Cooper and Ms. Williams. On the other hand, it seems evident that these providers did not view these situations as calls to action, perhaps because they felt the state psychiatric centers would not intervene constructively or perhaps because they so frequently saw similar situations, that the experiences of Mr. Cooper and Ms. Williams did not stand out as being significantly different, except for the tragic outcomes.

In any case, the community mental health providers did not provide the vital safety net for Mr. Cooper and Ms. Williams.

The Executive and Legislative branches of state government should carefully examine plans for the continued census rundown of state psychiatric centers.

Conclusions and Recommendations

Thus, as the Commission reviewed the care of Mr. Cooper and Ms. Williams, it often came to be that our understanding of what the law contemplates should have happened was not shared by the staff of the two state psychiatric centers or the many community providers we interviewed. What seemed to be serious oversights and inadequacies in care and services seemed to be the normal custom and practice.

The cases of Mr. Cooper and Ms. Williams provide the opportunity to call attention once again to the clear legislative intent and expectation regarding discharge planning and follow-up services. Toward that end, the Commission recommends that:

The Office of Mental Health should revise its regulations, policies, and practices to guarantee accountable monitoring and appropriate follow-up for patients discharged from state psychiatric centers.

1. The Executive and Legislative branches of state government should carefully examine plans for the continued census rundown of state psychiatric centers and ensure that these plans are accompanied by resources to develop a range of sufficient and appropriate community residential and support services to accommodate the needs of severely impaired persons who have long depended on the asylum offered by state institutions.

2. The Office of Mental Health should revise its regulations, policies, and practices to bring them into conformity with the intent of the specific requirements of Section 29.15 of Mental Hygiene Law, designed to guarantee accountable monitoring and appropriate follow-up for patients discharged from state psychiatric centers. Specifically, such monitoring and follow-up activities, whether they be done by the state psychiatric center or the community mental health provider, must:

   - assure that the patient's comprehensive medical, mental health, residential, and daily living needs are met;
   - provide for several direct contacts with the patient and providers of service during the first six months after his/her discharge;

Community hospitals now provide the vast majority of acute inpatient psychiatric care and are responsible for more than 80% of the discharged psychiatric patients statewide.

   - recommend and take steps to ensure the provision of any additional services needed by the patient; and
   - guarantee a reviewable record of all monitoring and follow-activities undertaken for the patient.

3. As the Office of Mental Health revises its policies and procedures for discharge planning for state psychiatric centers, it should also consider the need for new legislation and/or regulation to extend required provisions for discharge planning, monitoring, and follow-up activities to psychiatric units of community hospitals. As a result of recent changes in state mental health policy, community hospitals now provide the vast majority of acute inpatient psychiatric care and are responsible for more than 80% of the discharged psychiatric patients statewide. These statistics speak for themselves in justifying discharge planning safeguards for psychiatric patients served in community hospitals, as well as state psychiatric centers.

The adult home model of care, designed primarily as a custodial, not as a rehabilitative or clinical residential care model, is not adequate to meet the needs of many individuals with significant functional impairments due to serious mental illness and/or long years of institutionalization.

4. This report, like the Commission's October 1990 report, *Adult Homes Serving Residents with Mental Illness*, provides significant evidence that the adult home model of care, designed primarily as a custodial, not as a rehabilitative or clinical residential care model, is not adequate to meet the needs of many individuals with significant functional impairments due to serious mental illness and/or long years of institutionalization. Thus, the Commission strongly advocates for renewed consideration of the lead recommendation in its 1990 report that the Office of Mental Health should conduct a careful assessment of the level of care needs of individuals with mental illness living in adult homes and propose a more appropriate model of care to address the needs of these individuals.

The Office of Mental Health should establish clear standards and expectations for the performance of outpatient programs which operate in adult homes.

5. The Office of Mental Health should establish clear standards and expectations for the performance of outpatient programs which operate in adult homes and ensure that these programs address the basic rehabilitative needs of residents, such as their needs for assistance and training in personal hygiene, grooming, social interactions, and attending leisure time activities.

   In addition to these service expectations, OMH should ensure that all outpatient providers serving residents of adult homes:

   - establish effective and timely mutual procedures with the staff of the adult home to ensure communication of any significant problem or serious incident affecting one of its patients;
   - report significant problems or serious incidents occurring in the adult homes serving their patients (of which they become aware) to their respective OMH Regional Office and the responsible Regional Office of the Department of Social Services; and
   - report all allegations of abuse and neglect to the Commission on Quality of Care, their respective OMH Regional Office, and the responsible Regional Office of the Department of Social Services.

6. Inpatient psychiatric facilities which discharge patients to adult homes should routinely receive and review Department of Social Services' inspection reports on those homes to determine if conditions found during the Department's inspections are appropriate to the needs of their discharged patients or if they suggest that current residents should be relocated and future discharges suspended.

7. Outpatient mental health providers serving residents of adult homes should also receive and review the Department of Social Services' inspection reports on adult homes serving their patients to determine what bearing conditions found therein may have on the health, safety and well-being of their patients and to initiate appropriate clinical and advocacy measures. Further, outpatient staff serving residents of adult homes should be trained in the regulations governing adult homes and the standard of care expected of adult homes so that they can be better informed advocates of their clients' rights.

Appendix A

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

RICHARD C. SURLES, Ph.D., Commissioner

July 9, 1993

Clarence Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue - Suite 1002
Albany, NY 12210

Dear Mr. Sundram:

Thank you for the opportunity to respond to the Commission's confidential draft report Falling Through the Safety Net: "Community Living" in Adult Homes for Patients Discharged from Psychiatric Hospitals.

It is indisputable that the circumstances surrounding the two case studies detailed in the Commission's report were tragic. They, indeed, demonstrate that no service system is "incident proof" and that significant work remains to be done in the area of mental health services in adult homes.

Given these circumstances, the Office of Mental Health (OMH) believes that the most productive path lies not in reiterating problems but in focusing efforts on continued improvements. Many of the issues discussed in the current report are similar to those identified in the Commission's 1990 report on adult homes. Since that time, OMH and the Department of Social Services (DSS) have invested significant effort in improving mental health services provided in adult homes. The DSS/OMH Adult Home Work Group has been instrumental in these efforts. The newly developed service model to be piloted in New York City and the new prototype service agreement are examples of their work.

Details of these efforts are contained in the enclosed response and provide evidence of the quality improvement strategies that have been enacted. Responses from Manhattan Psychiatric Center and Pilgrim Psychiatric Center which address specifics of the two case studies in the Commission's report are being forwarded to you directly from those facilities.

If you have any questions or require any additional information, please contact Dr. Sandra Forquer, Deputy Commissioner for Quality Assurance and Information Systems Offices at (518) 473-6383.

Sincerely,

Richard Surles

Richard C. Surles, Ph.D.
Commissioner

cc: Sandra Forquer, Ph.D.

Recommendation #1:

The Executive and Legislative branches of state government should carefully examine plans for the continued census rundown of state psychiatric centers and ensure that these plans are accompanied by resources to develop a range of sufficient and appropriate community residential and support services to accommodate the needs of severely impaired persons who have long depended on the asylum offered by state institutions.

OMH Response:

The census rundown of New York State's psychiatric centers in recent years has resulted from a complex set of programmatic, fiscal and physical plant imperatives. Although the rundown has occurred during a prolonged period of state fiscal crisis, there has been modest but consistent growth in investment in community mental health resources. This growth is demonstrated by several current initiatives.

- Since May '92, OMH has approved more than 150 applications for new outpatient programs. Another 170 applications are currently under review.

- In FY 93-94 two million dollars has been allocated for Community Support Services programming. An additional one million dollars has been allocated to the development of psychosocial clubs.

- In the last five years, 2,555 new licensed housing beds have been developed including Community Residences and Residential Care Centers for Adults. Another 1,961 supported housing beds have come on line during this period.

- Ten Comprehensive Psychiatric Emergency Programs are now funded. Eight are fully operational and the other two will open by December '93.

Thus, despite severe fiscal constraints, expansion of the community mental health system remains a priority for OMH.

Recommendation #2:

The Office of Mental Health should revise its regulations, policies, and practices to bring them into conformity with the intent of the specific requirements of Section 29.15 of Mental Hygiene Law, designed to guarantee accountable monitoring and appropriate follow-up for patients discharged from state psychiatric centers. Specifically, such monitoring and follow-up activities, whether they be done by the state psychiatric center or the community mental health provider, must:

- assure that the patient's comprehensive medical, mental health, residential, and daily living needs are met;

- provide for several direct contacts with the patient and providers of service during the first six months after his/her discharge;

- recommend and take steps to ensure the provision of any additional services needed by the patient; and

- guarantee a reviewable record of all monitoring and follow-activities undertaken for the patient.

OMH Response:

Prior to receipt of the Commission's report, there had been increasing recognition that a variety of recent developments make it advisable for OMH to consider amending the current discharge regulations/policies. OMH's Bureau of Policy/Regulations will be undertaking a review of the existing discharge regulations and policies to determine if further clarification or enhancement of OMH's responsibility is appropriate.

However, many of the shortcomings in discharge planning, follow-up and monitoring identified in the Commission's report point not to the need for consideration of revision to current regulations/policies but to the need for adherence to established agreements and policies. In 1986 OMH and DSS signed the Interagency Agreement regarding Discharge Planning from State Operated Psychiatric Centers. The agreement details the respective responsibilities of the two agencies for a comprehensive range of discharge planning and follow-up activities. Its intent was to operationalize the requirements of Mental Hygiene Law (Section 29.15) and Social Services Law (Section 131.2) as they pertain to patients discharged to the community from State psychiatric centers.

This Interagency Agreement was designed to serve as the cornerstone for meeting the needs of patients transitioning from the hospital to the community and, if adhered to, can continue to serve that critical function. The findings of the Commission's report indicate that there may be a need to reinforce the importance of this agreement to ensure that its provisions are well understood and consistently implemented in the field.

Following the initial distribution of the agreement to all OMH facilities and regional offices, joint OMH/DSS training was conducted in the Hudson River, Central and Western New York regions. Due to mandated cutbacks in training and travel funds, similar training in the downstate regions was postponed. In view of this, OMH plans to assess the statewide need for additional training on the agreement and related policies. While particular emphasis will be placed on the training and implementation needs of facilities in the NYC and Long Island regions, the feasibility and necessity of conducting refresher training in upstate regions will also be explored.

Recommendation #3:

As the Office of Mental Health revises its policies and procedures for discharge planning for state psychiatric centers, it should also consider the need for new legislation and/or regulation to extend

required provisions for discharge planning, monitoring, and follow-up activities to psychiatric units of community hospitals. As a result of recent changes in state mental health policy, community hospitals now provide the vast majority of acute inpatient psychiatric care and are responsible for more than 80% of the discharged psychiatric patients statewide. These statistics speak for themselves in justifying discharge planning safeguards for psychiatric patients served in community hospitals, as well as state psychiatric centers.

OMH Response:

OMH concurs with the Commission's observation regarding the critical role played by the psychiatric units of community hospitals. In an effort to ensure appropriate delivery of discharge planning and follow-up services by these hospitals, plans are presently underway to extend the Tiered Certification process to the inpatient setting. The implementation of Tiered Certification has been a major step forward for OMH. The process is uniformly applied throughout all NYS regions and focuses on review and compliance with the most important elements of applicable regulations. It includes outcome measures and utilizes an objective scoring system which determines length of operating certificate and nature of enforcement activities.

Phase I of the Tiered Certification initiative is now fully operational and includes all certified outpatient programs. Phase II of the initiative is in progress and focuses on licensed housing settings. Draft standards have been developed and several pilots will be conducted in Fall '93. The goal is to implement Tiered Certification for licensed housing programs in early '94.

The third phase of the Tiered Certification initiative will focus on certified inpatient programs. A work group is presently being established and will include state and local representation as well as input from consumers. As key standards are identified for inclusion in the inpatient Tiered Certification protocol, the areas of discharge planning, monitoring and follow-up will be critical issues to be addressed. In view of the complexity of the inpatient environment and the range of issues to be addressed, it is anticipated that draft standards will be developed in '94. Feedback from the Tiered Certification inpatient project will be used to determine the need for revision to the current inpatient regulations.

In addition, as OMH undertakes its review of discharge planning regulations, it will pursue methods to conform the discharge planning requirements of state and community hospitals.

Recommendation #4:

This report, like the Commission's October 1990 report, Adult Homes Serving Residents with Mental Illness, provides significant evidence that the adult home model of care, designed primarily as a custodial, not as a rehabilitative or clinical residential care model, is not adequate to meet the needs of many individuals with significant functional impairments due to serious mental illness-and/or long years of institutionalization. Thus, the Commission strongly advocates for renewed consideration of the lead

recommendation in its 1990 report that the Office of Mental Health should conduct a careful assessment of the level of care needs of individuals with mental illness living in adult homes and propose a more appropriate model of care to address the needs of these individuals.

OMH Response:

As indicated in our response to the 1990 report, OMH believes that, rather than conducting a "blanket" assessment of all adult home residents with mental illness, the more productive approach is to develop a discrete service model which improves the capacity of adult homes to respond to the needs of these residents. Toward that goal, OMH has worked jointly with the Department of Social Services to reconfigure the model for provision of mental health services in adult homes serving significant populations of persons with mental illness. The newly reconfigured model that is being proposed would be organized around a framework which emphasizes accountability, continuity of care and crisis response. Programmatically, it would emphasize rehabilitative programming as the key to improving functional capacity. The new model would incorporate comprehensive case management to be provided by a designated mental health provider. Functions under consideration for the case management component include:

- Monitoring of the medication regimen of persons identified as having difficulty with medication management. Such cases could be identified by the adult home or the case manager or on the basis of the patient's history or current behavior.

- Follow-up with such persons to support them in adhering to appropriate medication regimens.

- Linkage to the physician/clinic/continuing day treatment program where medication is prescribed and monitored.

- Provision for training for adult home residents and adult home staff to better understand medication, its effects/side effects and relationship to the individual's functioning effectively in the community.

- Utilization of peer support and planned coping mechanisms consistent with the recovery model in addition to traditional "medical model" interventions.

As part of this model, there would be a requirement for written agreements, formal linkages and ongoing communication among providers of publicly funded mental health care. In addition, the programmatic requirements and reimbursement mechanism would place a premium on helping residents gain functional community living skills while dealing with symptomatology in ways that minimize the use of costly, inappropriate hospitalization.

Initially, this design will be introduced in four adult home facilities, three of which will be in the New York City region. Selection of facilities will be based on the operator's willingness to work cooperatively with the designated mental health provider and to assure continuous and meaningful communication between that agency and all other providers of care to the home.

OMH is in the process of designing patient assessment and evaluation components for this new model of service provision. Information from the patient assessment component will be utilized to help shape the design of the new model. The evaluation component will assess the impact of the model on variables such as level of functioning, client satisfaction, medication management and frequency of hospitalization.

Recommendation #5:

The Office of Mental Health should establish clear standards and expectations for the performance of outpatient programs which operate in adult homes and ensure that these programs address the basic rehabilitative needs of residents, such as their needs for assistance and training in personal hygiene, grooming, social interactions, and attending leisure time activities.

In addition to these service expectations, OMH should ensure that all outpatient providers serving residents of adult homes:

- establish effective and timely mutual procedures with the staff of the adult home to ensure communication of any significant problem or serious incident affecting one of its patients;

- report significant problems or serious incidents occurring in the adult homes serving their patients (of which they become aware) to their respective OMH Regional Office and the responsible Regional Office of the Department of Social Services; and

- report all allegations of abuse and neglect to the Commission on Quality of Care, their respective OMH Regional Office, and the responsible Regional Office of the Department of Social Services.

OMH Response:

OMH concurs with the Commission that clear standards and expectations for mental health services provided in adult homes are critical to the effectiveness of such services. The functions delineated in the new model for provision of mental health services in adult homes (see response #4) will be a major step forward in this area.

In a further effort to improve clarity regarding respective roles and responsibilities, a prototype joint service agreement was recently developed for use by the adult home and its mental health provider(s). The prototype service agreement details responsibilities for the following key areas:

- Referral, Screening & Admission

- Ongoing Assessment
- Coordination of services by more than one mental health provider
- Case Management
- Resident Supervision
- Emergency Mental Health Services
- Information Exchange
- Staffing/Coverage
- Dispute Resolution

The draft prototype will be reviewed by the DSS/OMH Advisory Committee on Mental Health Services in Adult Homes at its July meeting. The goal is to issue the prototype to the field in September 1993.

In regard to communication between the adult home and mental health provider regarding problems encountered by residents, the current DSS/OMH Joint Inspection Memorandum of Understanding supports this type of communication. Section IX of the MOU details the responsibility of DSS to investigate residents' complaints and incidents and notify OMH and the mental health service provider regarding these activities.

In addition, Section 9 of the draft prototype agreement requires details on information exchange between the adult home and the mental health service provider. It asks that the parties specify mechanisms for sharing critical information, including the frequency of meetings to coordinate the provision of mental health services.

In regard to incident reporting, OMH has recognized the need to strengthen reporting requirements for licensed outpatient providers. Revisions to the current incident reporting regulations (Part 524) are presently under consideration that would address the reporting issue identified in the Commission's report. Specifically, the definition of a reportable incident would no longer be restricted to that occurring at the site of the licensed mental health provider. Thus, serious incidents occurring in adult homes that come to the attention of the licensed mental health provider operating in that home would be required to be reported to OMH regional offices. This would include reporting of abuse/neglect allegations to CQC and OMH regional offices.

It should be noted that although it is not currently a statutory requirement, both the New York City and Long Island Regional Offices report that they do receive incident reports from mental health providers in adult homes as well as from case managers serving patients in these homes.

Any reporting of incidents/abuse allegations to DSS is, of course, governed by DSS's own incident reporting requirements, consistent with its authority as the licensing agency for adult homes.

Recommendation #6:

Inpatient psychiatric facilities which discharge patients to adult homes should routinely receive and review Department of Social Services' inspection reports on those homes to determine if conditions found during the Department's inspections are appropriate to the needs of their discharged patients or if they suggest that current residents should be relocated and future discharges suspended.

OMH Response:

OMH Regional Offices routinely receive DSS inspection reports and communicate with DSS staff regarding implications for placement of psychiatric center patients. Decisions to impose or lift moratoria on referrals from psychiatric centers are made at the Regional Office level and transmitted to the executive directors of psychiatric centers as well as to local mental health officials and directors of geographically adjoining regions. Findings from DSS inspection reports are utilized in making these decisions and there have been instances where such findings directly contributed to a decision to cease referrals to particularly problematic homes.

In regard to the issue of relocating current residents of a home, it should be noted that psychiatric centers do not maintain an indefinite legal relationship with former patients. OMH may assist with the relocation of willing residents, but it cannot compel their movement as though they were directly in OMH's care or custody.

Recommendation #7:

Outpatient mental health providers serving residents of adult homes should also receive and review the Department of Social Services' inspection reports on adult homes serving their patients to determine what bearing conditions found therein may have on the health, safety and well-being of their patients and to initiate appropriate clinical and advocacy measures. Further, outpatient staff serving residents of adult homes should be trained in the regulations governing adult homes and the standard of care expected of adult homes so that they can be better informed advocates of their clients' rights.

OMH Response:

OMH agrees that it is important for mental health providers operating in adult homes to be informed of DSS inspection findings. Current DSS regulations require that adult homes make available copies of all inspection reports to their residents and to the public. (OMH has similar requirements of its certified mental health programs.) Thus, these reports are available on-site to the mental health provider. The real issue involves getting adult home operators and mental health providers to regularly review each other's reports from the perspective of determining how they can collaboratively address deficiencies affecting their mutual clients. Toward that end, the draft prototype service agreement (referenced in #5) specifically articulates the expectation of regular review of inspection and certification reports.

Southside Hospital

301 East Main Street
Bay Shore, NY 11706-8458
516-968-3000

June 21, 1993

Mr. Clarence J. Sundram
Chairman
State of New York
Commission on Quality of Care
For the Mentally Disabled
99 Washington Avenue – Suite 1002
Albany, NY 12210-2895

Dear Mr. Sundram:

Thank you for providing us with the opportunity to review the draft report entitled Falling Through the Safety Net: "Community Living" in Adult Homes for Patients Discharged from Psychiatric Hospitals.

We take strong exception to the conclusions drawn relative to the treatment provided at Southside Hospital. Specifically, page 19 of the report identifies "the failure of Southside Hospital during Mr. Cooper's second visit to the hospital's emergency room (October 9, 1991) to remove his sutures, and fully explore the cause of his fever and abnormal lab values."

First, the role of an emergency department is to provide emergency care. While it might be perceived by some that an emergency department should provide comprehensive care, this is not the role of an emergency department. The standard of care for hospital emergency departments is not to routinely remove sutures unless they are infected or pose a medical emergency to the patient. In Mr. Cooper's case, the scalp sutures were in place 16 days at the time he was seen in Southside Hospital's Emergency Department. This is not an inordinate or dangerous period of time. While Mr. Cooper's triage nurse identified the presence of the scalp sutures, they were not infected nor was there any other reason to remove Mr. Cooper's sutures as part of an emergency department visit. Suture removal should be part of Mr. Cooper's ongoing care which should have been arranged for by his case worker or his adult home.

Second, the claim that Mr. Cooper had a fever at the time of his October 9, 1991 visit to Southside Hospital's Emergency Department is totally incorrect. Specifically, Mr. Cooper's temperature was 98.2°F as is documented on the Southside Hospital Emergency Department triage record. It should also be noted that Mr. Cooper's temperature on October 11, 1991 taken at the Brentwood Family Health Center was 98.5°F. His temperature taken in Southside Hospital's Emergency Department on October 16, and 18 was respectively 97.9°F and 99.6°F. Finally, on October 21, 1991, Southside Hospital's Emergency Department record indicates that Mr. Cooper's temperature was 97.3°F.

elevated temperature when seen in Southside Hospital's Emergency Department. As a matter of fact, for each of the aforementioned emergency department visits Mr. Cooper's vital signs were within normal limits. This includes blood pressure, heart rate and respirations. It should be noted that the matter of Mr. Cooper's temperature was discussed with Vicky Rinere from the Commission's staff and we were pleased to learn that the report will be amended to reflect that Mr. Cooper did not have a fever at the time of his October 9, 1993 emergency department visit.

The Emergency Department Physician did in fact adequately address Mr. Cooper's white blood count of 23,700. A comprehensive physical exam was done, which included a finding of normal vital signs, and a chest x-ray was performed. In light of Mr. Cooper's not having a fever and his clear lung sounds, the emergency department physician's clinical evaluation pointed to a possible pneumonia and a general, non-focused infection, which would respond to erythromycin which is a broad spectrum antibiotic which was administered to Mr. Cooper. The patient was instructed to seek follow-up care through the Brentwood Family Health Center and received a discharge instruction form which was to be given to the Adult Home. It should be noted that the official Radiology Report concerning Mr. Cooper's chest x-ray found no pneumonia but chronic interstitial markings, thoracic scoleosis and a slightly enlarged heart. Based upon the standard of care for Mr. Cooper's presenting condition, it is unclear what other actions should have been taken in addition to that which was done in the emergency department. An admission to Southside Hospital would be inappropriate because Mr. Cooper did not present with an acute medical problem.

The report also "questioned why the staff of Southside Hospital's Emergency Room did not follow-up on Mr. Cooper's poor hygiene noted during his September 25, 1991 and October, 1991 visits." It is unrealistic to expect that an emergency department staff should follow-up poor hygiene when the patient's poor hygiene did not adversely affect their medical condition. In the case of Mr. Cooper, while the staff noted his poor hygiene, there were no associated problems such as ulceration, maggots, lice, ecchymosis, physical abuse, and/or lacerations which would indicate that Mr. Cooper was in imminent medical danger. There are many patients who are treated in Southside Hospital's Emergency Department who exhibit poor hygiene. However, unless the patient's poor hygiene materially affects their health status, the standard of care for an emergency department is not to admit that patient or take special steps to provide follow-up as a result of the patient's poor hygiene. What is interesting to note is Mr. Cooper's history of poor hygiene. In this regard, it is not within the purview of an emergency department to take a primary role in changing an individual's lifestyle, eventhough that lifestyle may be perceived as being detrimental.

In addition to the aforementioned concerns, we also take exception to the tone and tenor of the report and the innuendo relative to the care rendered by Southside Hospital's staff. In particular, on page 14 of the report, it is indicated that "both the physician and triage nurse were the same medical personnel that had examined Mr. Cooper during his previous emergency room examination." While this statement is true, implicit in the report is the impression that the staff should have remembered Mr. Cooper and should have acted differently. The reality is that it is unreasonable to assume that staff members working in a very busy emergency department should remember patients seen six days previously. More importantly, the care rendered to Mr. Cooper for each of the emergency department visits was appropriate.

In a similar fashion it is unclear what the Commission's rationale is other than negative innuendo and taking information out of context when on page 14 of the report a highlighted statement is made about Southside Hospitals' discharging physician offering "no other explanation why Mr. Cooper was being discharged back to the Brentwood Adult Home, despite the hospital's initial concerns regarding the homes neglect of his care and supervision."

Southside Hospital

01 East Main Street
Bay Shore, NY 11706-8458
16-968-3000

June 23, 1993

Mr. Clarence J. Sundram
Chairman
State of New York
Commission on Quality of Care
For the Mentally Disabled
99 Washington Avenue – Suite 1002
Albany, NY 12210–2895

Dear Mr. Sundram:

While we have previously corresponded to you concerning the draft report entitled Falling Through the Safety Net: "Community Living" in Adult Homes for Patients Discharged from Psychiatric Hospitals as it relates to the care received by Mr. Cooper at Southside Hospital, we also feel it appropriate for us to comment upon other aspects of the report.

Philosophically, we strongly support the concept of placing mentally disabled individuals in the least restrictive environment. Placement within the community is preferable to institutional care so long as each patient has available to them comprehensive community supports including medical, psychiatric and social work services.

Because Southside Hospital serves the communities of Brentwood, Central Islip, and Bay Shore, we are keenly aware of the problems faced by former State Psychiatric Center patients. While they might medically be ready for discharge to the community, without adequate support systems, many of these discharges will fail. First and foremost is the need for adequate housing with staff who are trained to provide the services this special population requires. Adult homes may not be the best place for these patients. This is especially true in light of the reimbursement available to place mentally disabled persons in an adult home. By and large these individuals receive Social Security and Supplemental Security Income in the range of $600–$900 per month. With this amount available, there are very few, if any, adult homes that will care for these patients. In addition, of those adult homes that serve this special population few, if any, have the requisite support systems necessary. What is needed are on–site specialists, including social workers and case managers for these individuals. In particular, mentally disabled persons need to receive services from individuals who will serve as concerned surrogates helping them negotiate the environment found in a community setting.

community models of care that are specifically designed to support the needs of the mentally disabled. While such a change requires additional funds, we feel that such funds can and should come from the savings that have accrued and will result from the downsizing of the large State Psychiatric facilities. We, therefore, endorse the proposed legislation that calls for the reinvestment of these savings into the mental health community service system. It is our belief that a strong community service system can reduce acute care utilization and result in a better life for the mentally disabled.

Once again, feel free to call upon us in your efforts to improve the current system of community mental health services.

Sincerely,

Theodore A. Iospe,
President

TAJ:kpd

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

GREGORY M. KALADJIAN
Acting Commissioner

(518) 474-9475

July 1, 1993

Mr. Clarence J. Sundram, Chairman
New York State Commission on Quality
of Care for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, New York 12210-2895

Dear Mr. Sundram:

The Department has received and reviewed the Commission's draft confidential report of May 1993 entitled "Falling Through the Safety Net: 'Community Living' in Adult Homes for Patients Discharged from Psychiatric Hospitals."

We find the report to be a reasonable presentation of some of the weaknesses which exist in the integration of adult care facility and mental health services. We have responded in detail to earlier reports, most recently in my letter of June 18, 1993 on the Commission's report on New Queen Esther. With regard to Brentwood, we initiated a number of enforcement actions in 1990 and 1991 based on non-compliance with the standards for medications management, staffing and related problems. These actions resulted in the collection of $3200 in fines in August, 1992. The facility continues to be closely monitored by the Department.

Let me continue to assure you that we consider the improvement of services for mentally ill persons living in adult homes to be of the utmost importance. Staff from the Office of Mental Health and this Department have been working together on proposals to re-design and re-configure the community-based mental health services available to adult care facility residents. Better service planning coupled with models which assure case management, access to out-patient services and health services, crisis response and rehabilitation are essential. Staff have met with your staff regularly on these issues. We are in the process of reconstituting the advisory group, with expanded representation from the resident advocate groups, which was so helpful in the development of the joint OMH/DSS workplan.

At the same time the Department is working closely with the Office of Mental Health to address compliance and quality of care issues in specific facilities. Those efforts were detailed in my letter of June 18th.

I appreciate the opportunity to review this draft report. We continue to rely on the Commission's support to improve services in this critical level of care.

Sincerely,

Gregory M. Kaladjian

First, it is unclear whether this question was specifically raised with the physician by the Commission's Staff. Second, the Brentwood Adult Home was licensed by the New York State Department of Social Services, and therefore had the proper licensure to provide Mr. Cooper the services he required. Third, Mr. Cooper's Case Manager raised no objections to the Hospital's staff about returning Mr. Cooper to the Brentwood Adult Home.

In light of the aforementioned, we would hope that the Commission's report is amended to more accurately represent the medical care Mr. Cooper received at Southside Hospital. Specifically, the care received by Mr. Cooper did in fact meet the standard of care. While we are sympathetic with the Commission's expectation that a hospital and its emergency room should serve as the social safety net for adult home patients, for patients with hygiene problems and for those individuals in society that are not being well served by government agencies, it is an unrealistic expectation.

We are more than willing to meet with the Commission's staff and the Commission's Medical Review Board to discuss this case and how we might better serve our patients. Feel free to call upon me, and my staff to discuss the role hospitals can play in the continued care received by the mentally disabled.

We have, under separate cover, submitted to your office our thoughts and observations concerning the deinstitutionalization of patients like Mr. Cooper.

Sincerely,

Theodore A. Jospe,
President

TAJ:kpd

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CLARENCE J. SUNDRAM
CHAIRMAN

ELIZABETH W. STACK
WILLIAM P. BENJAMIN
COMMISSIONERS

August 13, 1993

Theodore A. Jospe
President
Southside Hospital
301 East Main Street
Bay Shore, NY 11706-8458

Dear Mr. Jospe:

This is in response to your letter of June 21, 1993 in which you commented on the Commission's draft report entitled Falling Through the Safety Net: "Community Living" in Adult Homes for Patients Discharged from Psychiatric Hospitals.

In the letter you expressed concern over the Commission's and Medical Review Board's findings and conclusions regarding Southside Hospital's treatment of Nicholas Cooper, a pseudonym for the deceased. Specifically, you disagreed with our conclusions that:

- sutures should have been removed from Mr. Cooper's scalp when he visited the hospital's emergency room (ER) on October 9, 1991;
- the facility should have taken additional actions on October 9, 1991 when Mr. Cooper presented in the ER with an elevated white blood count (WBC) and possible pneumonia; and
- hospital staff should have followed up on Mr. Cooper's poor hygiene noted during his various ER visits in September and October 1991.

Commission staff and physician members of the Medical Review Board have considered your comments, reexamined Mr. Cooper's records and history, and stand by the opinions expressed initially in the draft report.

While the sutures present in Mr. Cooper's scalp during the October 9 ER visit did not pose a medical emergency, Medical Review Board members noted that the sutures had been placed 16 days earlier by Southside ER staff and had not been removed, as recommended, by the time of the October 9 ER visit. The Medical Review Board physicians took issue with Southside's response that 16 days is an acceptable period of time to leave sutures in a scalp wound, and opined that it would have been good and compassionate patient care to have removed the sutures at the time of the October 9 ER visit.

The Medical Review Board members also remained uncomfortable with Mr. Cooper's management during the October 9 ER visit when he presented with an elevated WBC and pneumonia was suspected. They noted that with the exception of a normal temperature, the patient evidenced essentially the same symptoms as he did during a previous, September 1991, ER visit. In response to the findings of the September ER visit, Southside Hospital admitted Mr. Cooper for inpatient care, and treated him aggressively for pneumonia with IV antibiotics. Yet, when Mr. Cooper presented with similar symptoms on October 9, he was released from the ER with a prescription for oral erythromycin. Board physicians commented that the management of Mr. Cooper on these two occasions was inconsistent, and less aggressive on the second visit.

Finally, Board members were troubled by the attitude reflected in Southside Hospital's response regarding the obligations of an ER when it encounters evidence of poor hygiene and neglect, particularly when the patient is a resident of a State-operated or -certified facility. While it is true that ER's have no statutory obligation to pursue all cases of suspected abuse/neglect, as they must do in cases of suspected child abuse/neglect, ER's frequently encounter illness, injury or conditions resulting from, or associated with, socio-economic factors. In the Board's opinion, ER's should ensure the involvement of appropriate social service departments in such cases in an attempt to resolve some of these conditions or factors.

In light of the Board members' comments, the Commission will not amend its draft report, other than to correct an error in fact concerning Mr. Cooper's temperature during the October 9, 1991 ER visit. We will, however, include Southside Hospital's response and comments in the final report.

Thank you for this opportunity to consider and respond to your comments.

Sincerely,

Clarence J. Sundram
Chairman

The Commission requests that the Office of Mental Health address each of the above concerns specifically in its 90-day response to the final report. In addition, we would appreciate being informed of time frames for the implementation of promised corrective actions with regard to each recommendation. The Commission would appreciate a response by November 2, 1993.

Thank you.

Sincerely,

Clarence J. Sundram
Chairman

Enclosure
cc: Peggy O'Neill
Michael Ford, M.D.

SIMON HALPERT
SARAH HALPERT
PROPRIETORS

Brentwood Adult Home

147 SECOND AVENUE :: BRENTWOOD, N. Y. 11717

July 22, 1993

Dear Mr. Sundram,
Enclosed you will find our response to the confidential draft that I received from you concerning a former resident of mine (pseudomyn; Nicholas Cooper.)

One can only be disheartened in reading your report, Falling Through the Safety Net: in Adult Homes for Patients Discharged from Psychiatric Hospitals, and in the case of Michael Cooper, a resident of this facility from July 25, 1991 to October 22, 1991, a concurrance in your conclusion: few excuses" and more than enough blame to be shared by all.

Unfortunately, your hypothesis is correct that we as providers are faced too frequently with situations similar to Mr. Cooper"s. While his problems may not be different, we are certain that the care provided to the other residents at BAH is significantly different from that described in your report.

The report attributes the problems of Mr. Cooper which is then interpolated to the entire universe of residents to two basicfailings: 1) an inappropriate admission policy, and 2) a systemic inability to respond to our patients' needs. We believe both conclusions to be erroneous.

In making admission decisions to Brentwood we depend on our own personal interview with each resident as well as a review of discharge summaries provided by professionals within the mental health system. The interviews are conducted in conjunction with the mental health aftercare team which will be responsible for providing services to the individual resident. The decision to admit a resident is based upon the team's evaluation as to whether we are able to meet the current and future needs of the applicant. Any evaluation of the future mental health status of individual applicants is, however, problematic. Patterns of behavior of mental health dischargees, particularly those who have been institutionalized for most of their adult lives, are difficult to predict.

It appears that Mr. Cooper was an appropriate admission, but that his status deteriorated precipitately. We observe that he was discharged to the Brentwood facility on July 25 and was seen by various providers, including those who later observed his "atrocious hygienic condition," on August 12 August 22 and September 19. On no occasion was his personal hygiene commentedupon. On September 24, Mr. Cooper's personal appearance apparently significantly declined. It should be noted that on October 18, however, a DSS investigator observed, "Even though it is likely that theresidents's appearance when at the hospital was as decribed, his appearance this date was quite acceptable."

Our records notes indicate that Mr. Cooper had to be constantly reminded to shower, shave and change his clothes. During that DSS visit, our staff reported that "for a couple of weeks Mr. Cooper had been resistent to caring for his personal hygiene." It seems clear that the efforts of our staff were unsuccessful in responding to Mr. Cooper's hygiene needs and that no one else in the continuum of care, except one physician who admitted Mr. Cooper to Southside Hospital, was any more successful in responding to those needs, a poor safety net indeed.

The second conclusion in the report relates to our lack of compliance with DSS inspections. The Dss evaluation system has been a concern to us and to the entire adult home industry. DSS makes no differentiation between paper work errors and errors of care. For example, in your Figure 6, the last item observes that the operator failed to provide each resident with a personal allowance account statement at least quarterly. There is no indication that the personal allowance accounts were not accurate or that there was anything untoward in the financial relationship between the residents and this home. While we agree that the regulations require such quarterly allowance statements, we query what benefit such a statement would have been to Mr. Cooper.

Many of the DSS described "recurring problems" similary reflect a lack of documentation rather than a programmatic deficiency. Our failure on one inspection to record on the activities calendar the name of the individual conducting activities and our failure to note the location change of another resulted in an inspection report which read, "The operator is not maintaining an organized and diversified program of individual and group activities." We believe that it is somewhat inconsistent on the commission's part to be critical of the DSS ibspections and then rely on those same inspections to draw universal conclusions regarding the care provided in this or any other facility.

Explanations and intellectual post mortems do not change the reality for Nicholas Cooper or Serena Williams. We share with you thefrustration at the disjointed method by which services are made available for adult home residents. We believe that a more coordinated approach with responsibility in a single individual for overseeing overall care is a necessary first step in developing an affordable, responsive program for mental health dischargees who are residents of adult homes.

Enclosed is a copy of a letter which our association has forwarded to a number of legislators outlining the problem and seeking legislative solutions. I and our association are most eager to join with you in petitioning the Legislature and the Executive to help prevent any other Nicholas Coopers from falling through the safety net.

Sincerely,

Simon Halpert

Simon Halpert

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CLARENCE J. SUNDRAM
CHAIRMAN

ELIZABETH W. STACK
WILLIAM P. BENJAMIN
COMMISSIONERS

August 13, 1993

Honorable Richard C. Surles, Ph.D.
Commissioner
NYS Office of Mental Health
44 Holland Avenue
Albany, New York 12229

Dear Dr. Surles:

Please find enclosed an advance confidential copy of the Commission's report, *Falling Through the Safety Net: "Community Living" in Adult Homes for Patients Discharged from Psychiatric Hospitals.* I would also like to take this opportunity to comment on the Office of Mental Health's response to the draft of this report and particularly its recommendations for corrective action.

Despite OMH's general endorsement of the importance of the problems identified in the draft report and the thrust of its recommendations, the response does not specify concretely what corrective actions are planned and when they will be put in place to ensure that similar problems will not recur. As OMH notes, these problems have persisted since our last report on adult homes in 1990. Thus, it is a matter of concern to us that there be an accountable process to assure that necessary corrective actions are in fact taken and that they are effective in remedying the problems.

Specifically, the response does not enumerate concrete actions that the Office of Mental Health will be taking to direct state psychiatric centers to assure appropriate discharge planning decisions for individuals, which reflect accurate assessments of their functional abilities and the appropriate involvement of family members. The response also does not indicate whether or when the Office will be taking specific corrective actions to direct state psychiatric centers to provide follow-up of patients discharged from their care, in accordance with Mental Hygiene Law and the basic elements of appropriate follow-up, identified in the Commission's report.

The response also does not specify how the statewide implementation of tiered certification for inpatient psychiatric units (which OMH staff have informed Commission staff is still months, if not years from accomplishment) will obviate the need to extend the state's existing statute governing discharge planning for state psychiatric centers to inpatient psychiatric units of community hospitals, which now provide that largest percentage of hospitalizations for persons with serious mental illness in New York. Given the severity and persistence of the problems which have surfaced with regard to discharge planning in recent Commission investigations and studies of community hospitals, it seems to us that it is important that there be clear performance expectations, with the force of law, to guide hospitals in their discharge planning obligations, and against which their performance can be monitored, by OMH and the Commission.

The actions spelled out in the Office's response also do not appear to assure that important communication will occur between on-site mental health providers, adult home operators, and the regulatory agencies for both entities regarding serious incidents, problems related to individual residents, or more systemic concerns. There is much discussion in the response about the evolution of a memorandum of understanding between OMH and DSS on these issues, but there is no clarity as to whether OMH will require that all on-site mental health providers in adult homes to comply with specific "communication" expectations surrounding incidents and other problems noted in the report's recommendations.

The OMH response also appears to indicate that state psychiatric centers will not be required *or expected* to regularly review DSS certification/inspection reports on adult homes to which they discharge patients. The rationale for not assuring this most basic communication of information about adult homes with state psychiatric center staff making discharge decisions is not explained or justified in the OMH response, and appears to be inconsistent with the intent of the Mental Hygiene Law §29.15 subd. (h)(1) which requires the facility to make a determination of whether the residence is "adequate and appropriate for the needs of such patient."

Finally, the Commission continues to believe that a higher overall level of care, supervision, and services is required for adult homes serving a high percentage of persons with serious and long-standing mental illness. Although it is noteworthy that OMH has recognized the need to provide more accountability for the on-site mental health services it funds and/or licenses in adult homes through a pilot of a new model of mental health service delivery in three adult homes, the Commission believes that this approach will not address the substantial gap between the expected adult home level of care and the functional needs of most residents in adult homes, whose population is almost exclusively comprised of persons who are seriously mentally ill and who have had long histories of institutionalization.

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CLARENCE J. SUNDRAM
CHAIRMAN

ELIZABETH W. STACK
WILLIAM P. BENJAMIN
COMMISSIONERS

FROM: Clarence J. Sundram

DATE: August 27, 1993

SUBJECT: **Falling Through the Safety Net: 'Community Living' in Adult Homes for Patients Discharged from Psychiatric Hospitals**

Enclosed is a report stemming from the Commission's investigations of two deaths involving long-term psychiatric center residents who lacked the ability to survive in the community, but who were inappropriately discharged to chronically deficient adult homes. Their stories illustrate and underscore the problems inherent in rapidly reducing inpatient census without a comprehensive and coordinated system of residential and other support services for patients leaving state psychiatric centers for community-based treatment.

For several years now, we have been documenting the problems experienced by persons with severe mental illness who reside in substandard adult homes certified by DSS. In our view, the correction of these problems requires 1) that psychiatric hospitals comply with discharge planning laws and cease the practice of discharging severely mentally ill patients to facilities that are neither "adequate" nor "appropriate" to meet their needs (MHL § 29.15, subd. (h)); 2) that a new level of care be created to equip adult homes predominantly serving the mentally ill with the professional capacity to meet the foreseeable needs of their residents; and 3) more swift and effective enforcement of laws and regulations focused on improvement of living conditions in substandard homes.

Although the Commission has repeatedly made these recommendations to both OMH and DSS, conditions remain substantially unchanged, and we see little prospect that these fundamental problems will be addressed in the near future.

In this case, Commission investigation determined that two severely mentally ill individuals, Mr. Cooper and Ms. Williams (pseudonyms), who had lived 30 and 40 years respectively in state psychiatric centers, were abruptly discharged to adult homes that repeatedly had been cited for serious deficiencies affecting residents' health and safety, and which were ill-prepared to provide the services and daily living assistance the two patients needed.

(over)

The Commission investigation found that both psychiatric center staffs failed to meet their legal responsibilities to ensure appropriate discharge planning and followup, and that community mental health and social service agencies also failed to coordinate and deliver medical and outpatient mental health care, and case management, after their discharge. The Commission found such omissions were viewed by staff as normal practice, indicating a basic lack of understanding of their responsibilities under law and regulations.

As our report indicates, many long-term patients are not ready or able to live independently outside the psychiatric centers which have provided their total care for so many years, without considerable support and supervision. This level of support does not currently exist in most of the state's communities, where a loose patchwork of programs typically provides services for seriously mentally ill persons living in the community. As the Commission's discharge planning study released a few months ago found, in most areas there is no single place or a reliable process to coordinate and deliver services to meet long-term patients' "safety net" needs for food, clothing, shelter, medical and psychiatric care.

Our report recommends that plans for further psychiatric center inpatient census reductions be accompanied by adequate resources to develop a range of community residential and support services for severely impaired patients who have long depended on the overall protection and care of state institutions. We also recommend OMH consider legislation or regulations to extend discharge planning and followup requirements to psychiatric units of community hospitals, which currently provide most acute inpatient care and are responsible for over 80% of discharged patients statewide. However, these actions do not obviate the need for the corrective actions cited earlier.

The findings, conclusions and recommendations of the Commission report reflect the unanimous opinion of the members of the Commission. A draft of this report was reviewed by OMH and DSS. Their responses are appended to the report.

The report is filed in Accordance with Article 6 of the Public Officers Law and is considered a public document.

Gary W. Masline (W) 518-473-7538
(H) 518-427-1718

Embargoed for Release A.M. Wednesday, August 25, 1993

Adult Home Deaths Reveal Missing Safety Net for Mentally Ill

Two deaths involving long-term psychiatric center residents discharged to chronically deficient adult homes have prompted a call for psychiatric center staff to comply with laws on discharge planning and followup, and for a coordinated "safety net" of residential and support services in the community for patients leaving state psychiatric centers. A state "watchdog" agency report cited the residents' experiences as examples of New York State's difficulties in moving away from a largely institutional-based mental health care system, as more patients are discharged to live in adult homes and receive community-based treatment.

The State Commission on Quality of Care for the Mentally Disabled, an independent agency responsible for oversight in the mental hygiene system, today released a report, entitled "Falling Through the Safety Net: 'Community Living' in Adult Homes For Patients Discharged From Psychiatric Hospitals." According to the Commission report, two severely mentally ill individuals, referred to as Mr. Cooper* and Ms. Williams,* who lived 30 and 40 years respectively in state psychiatric centers, were abruptly discharged to grossly deficient adult homes unable to provide the services and daily living assistance each needed, or to manage their difficult behaviors. Both adult homes had long histories of failing to give residents safe shelter, adequate meals, supervision, medication management help, and leisure activities. In both cases, psychiatric center staffs failed to meet their legal responsibilities for discharge planning and followup, and community mental health and social service agencies failed to coordinate and deliver medical and outpatient mental health care, and case management, after their discharge.

Mr. Cooper, despite continuing delusions and inability to care for himself after 30 years of institutional care, was discharged by Pilgrim Psychiatric Center in July of 1991 to the Brentwood Adult Home in Suffolk County, just 8 days after his treatment team concluded he did not meet discharge criteria. Brentwood, which received non-compliance ratings from the State Department of Social Services (DSS) for 1982 - 1991, subsequently neglected Mr. Cooper's personal care and hygiene needs and mismanaged his medication. Several service providers noted he was usually very dirty and unkempt, but most did nothing to intervene. During his less than 3 months at the home, Mr. Cooper received very few scheduled services and fell several times, necessitating trips to the hospital. Information about his medical condition was not communicated among service agencies or aggressively explored by Southside Hospital in Bayshore. Mr. Cooper died of cardiac complications on October 22, 1991.

60 year old Ms. Williams was unable to speak, withdrawn and incapable of even washing or dressing herself. Yet, after 40 years of institutionalization she was discharged in 1991 by Manhattan Psychiatric Center to the New Queen Esther Home For Adults, in Queens, which could not handle her behavior or provide the services

*Pseudonyms

(more)

she needed. New Queen Esther had been cited repeatedly for filthy and dangerous conditions by DSS. The Commission in a recent report[1] characterized New Queen Esther as "a facility out-of-control" due to its history of incidents of resident assaults and acting out behavior, pleas by staff for assistance with problem residents, and calls to police. In 15 previous DSS certification inspections since 1980 it had been cited for dirty and unsafe living conditions. An on-site mental health team apparently was unaware of the problems or their impact on the safety and well being of residents, and an April 1993 DSS review found 128 violations of state regulations.

In October, 1992 when Ms. Williams deteriorated and began harming other residents, adult home staff noted in the logbook "please do something about her before she hurts someone seriously" and requested her hospitalization. But no action was taken and, the next day, a series of escalating incidents ended with her assault of an 83 year old resident, causing serious injuries from which the resident later died. The death was later classified a homicide. At the time, a direct care staff member, who had been left alone on her first day of work to supervise the home's more than 40 residents, could not manage the crisis.

Many long-term patients are not ready or able to live outside the psychiatric center without considerable support and supervision, which the Commission report says does not exist currently in most communities. Presently, a loose "patchwork" of programs performs services for seriously mentally ill persons in many communities, but there is no one place or a reliable process to coordinate and deliver services to meet long term patients' basic needs for food, clothing, shelter, medical and psychiatric care.[2]

The Commission report recommends that plans for further inpatient census reduction at state psychiatric centers include commitment of adequate resources to develop a range of community residential and support services for severely impaired patients who have depended for so long on the overall protection and care of state institutions. The Commission also recommends the State Office of Mental Health (OMH) consider legislation or regulations to extend discharge planning and followup requirements to psychiatric units of community hospitals, which currently provide most acute inpatient psychiatric care and are responsible for over 80% of the discharges of psychiatric patients statewide. Also, as recommended in its October 1990 report on adult homes,[3] the Commission again urged OMH to assess the level of care needed by adult home residents with mental illness, and to develop a more appropriate model of care to better address their clinical needs and functional limitations.

In response to a draft of the Commission report, OMH and DSS generally agreed with the Commission's findings. OMH has halted admissions to New Queen Esther. DSS has decided not to renew the facility's operating certificate, and will hold hearings on further enforcement action.

In New York State, approximately 10,000 mentally ill persons reside in adult homes, which are the largest community-based residential service for persons with mental illness, providing residents assistance in daily living and linkages to clinic services in the community. The Commission is required by the State Mental Hygiene Law to review deaths of mental health program recipients to determine whether circumstances surrounding a death suggest deficiencies in care. The Commission also advises the Governor and Legislature on mental hygiene policy.

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1 *Life and Death at New Queen Esther Home for Adults*, June 1993.

2 *Discharge Planning Practices of General Hospitals: Did Incentive Payments Improve Performance?*, New York State Commission on Quality of Care for the Mentally Disabled, April 1993.

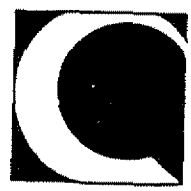
3 *Adult Home Residents with Mental Illness: A Study of Conditions, Services and Regulations*, October, 1990.

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-473-7538.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TDD)



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