New York State Documents

In the Matter of R.H.:
A Patient at Manhattan Psychiatric Center

A Report

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

April 1995

In the Matter of R.H.:
A Patient at Manhattan Psychiatric Center

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NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Preface

This report recounts the story of R.H., a 42 year old man with a 20 year history of drug abuse and serious mental illness resulting in multiple arrests, numerous psychiatric hospitalizations and homelessness. R.H.'s actions on January 4, 1995 ten days after his elopement from Manhattan Psychiatric Center (MPC) made headlines when he allegedly pushed a 63 year old woman into the path of an oncoming subway train, killing her. That tragedy and a similar one several weeks earlier when a patient, shortly after returning from an elopement, allegedly stabbed to death a fellow patient at Kingsboro Psychiatric Center, focused public attention on the adequacy of security measures at OMH psychiatric facilities in New York City for patients with histories of violent behavior.

These events raised questions about procedures followed when psychiatrists determine a patient is ready for grounds privileges, questions about the adequacy of search efforts and notification to families, police and other relevant parties when patients elope, and questions about the adequacy of perimeter, building and ward security in light of the many elopements from reportedly locked wards. Finally, the tragedy of January 4, 1995 raised fundamental questions about how to treat patients with serious mental illness, who often have concomitant drug abuse problems, whose repeated refusal to take psychotropic medication after discharge leads to decompensation and, in some cases, to aggressive and criminal behavior.

The tragedy of January 4, 1995 raised fundamental questions about how to treat patients with serious mental illness, who often have concomitant drug abuse problems, whose repeated refusal to take psychotropic medication after discharge leads to decompensation and, in some cases, to aggressive and criminal behavior.

The end result of R.H.'s Christmas Eve elopement from Manhattan PC — the loss of life of an innocent woman — was singular in its brutality; however, the behavior that led to the killing was not unique, rather it was a repetition of a pattern played out many times over the previous 20 years and, most importantly for the mental health system, this pattern is increasingly representative of many young men receiving public mental health services.

From 1974 to 1994, R.H. was hospitalized for mental illness on at least 15 occasions with stays from four days to two and one-half years. In each of these hospitalizations in several different hospitals, R.H. was diagnosed as schizophrenic with cocaine and alcohol abuse as either a primary or secondary diagnosis. During the same period, R.H. was arrested approximately one dozen times for various misdemeanors and felonies, including charges that he struck a woman on the street in 1983 causing a concussion, assaulted a woman in the subway with an umbrella in 1984, and slashed the face of a subway passenger with a straight razor in 1988. R.H. spent time in correctional facilities for some of his crimes, and while in prison in 1989 received mental health services through an OMH satellite clinic. (These clinics serve as the outpatient arms of Central New York Psychiatric Center, the inpatient psychiatric facility for prisoners in New York State.) Most often, however, R.H. was committed to a psychiatric facility rather than prosecuted.

During all but his shortest stays, R.H. typically eloped, sometimes returned voluntarily and sometimes was discharged when he failed to return. Drug testing results after R.H.'s return were often positive.

This pattern was replayed most recently in 1994. R.H. was admitted to MPC from a shelter in March, when he was believed to be responding to auditory hallucinations to hurt people. One month later, he eloped on the first day he was permitted to attend centralized rehab programming. He was officially discharged four days later, and noted not to be a danger to himself or others.

Although the presence of R.H.'s complete criminal history or "rap sheet" would have alerted staff to the fact that he had been convicted of slashing a man's face on the subway with a razor in 1988, it is not clear that this information would have made a difference in MPC's decision to grant R.H. grounds rights.

Within six weeks, having been without psychotropic medication, R.H. was again admitted to Manhattan PC "floridly psychotic." Within two months he again eloped from MPC, returned a day later and had a positive urine toxicology for marijuana. Five days after his first unauthorized leave, R.H. eloped again on July 20, 1994 and was returned six days later by his Intensive Case Manager (ICM). Approximately a month later, on August 30, R.H. eloped again and returned in two days. Again, drug testing was positive for marijuana. In late November, R.H. was granted unescorted grounds privileges. One month later on Christmas Eve, R.H. left the facility again and on January 4, 1995 was arrested, charged with 2nd degree murder and sent to the forensic ward at Bellevue Hospital Center for evaluation.

Commission findings regarding the care and treatment of R.H. include the following:

Access to Information

- During R.H.'s most recent hospitalization at MPC, staff had sufficient information available to them to know of his history of multiple psychiatric hospitalizations, incarcerations, substance abuse, leaves without consent, and violent assaults, with which to adequately treat R.H. as well as to assess his readiness for grounds rights and his potential for danger to others after elopements. However, they did not review all the information available to them from prior admissions at MPC, nor did they seek the records of hospitalizations at other psychiatric facilities. (Report p. 12)
- Although the presence of R.H.'s complete criminal history or "rap sheet" would have alerted staff to the fact that he had been convicted of slashing a man's face on the subway with a razor in 1988, it is not clear that this information would have made a difference in MPC's decision to grant R.H. grounds rights. The team's knowledge of R.H.'s other violent acts in the past did not prevent the team from granting grounds passes or from classifying his elopements as non-dangerous during this and his prior 1994 admission to MPC. (Report pp. 5, 6, 13)
- It appears that the clinical reasoning of staff at MPC, which assessed R.H. as suitable for ground rights and not dangerous to himself or others after his elopements, was also evidenced at Bronx PC in 1990. (Report p. 4)
- While the "rap sheet" would also have alerted staff to the outstanding bench warrant for R.H.'s arrest (since April 1993) for criminal possession of a weapon, menacing and disorderly conduct, it remains unclear if MPC would have been able to alert the police to his whereabouts or whether clinicians would have felt bound to maintain his confidentiality. While rap sheets are available for CPL patients, the issue of access to rap sheets for non-CPL patients, previously raised with MPC by CQC in 1993 had been referred to OMH Counsel over a year ago and remains under review.

Granting of Grounds Rights

- Despite four LWOC's from MPC during his two hospitalizations in 1994 (prior to December 24, 1994), R.H. was granted grounds rights several times, the last being November 23, 1994 on the Mentally Ill Chemical Abuse (MICA) Unit. (Report pp. 6-8)
- MPC's MICA unit houses a patient population that is high risk for elopement and dangerous behavior. According to MPC staff, many of the 124 patients (14% of the total MPC census of 890) on the four wards which comprise the MICA unit, including one open ward, have a history of violent behavior, noncompliance with medication (out of hospital) and substance abuse, which have been associated with future violent

behavior.[1] During 1994, 28 percent of all LWOCs (158/569) and 37 percent of all escapes (97/264) from MPC were from the MICA unit. In addition, 18 percent of LWOCs (102/569) and 20 percent (52/264) of escapes were from the Admissions Unit, from which the MICA patients are generally referred.

- The issue of the granting of grounds rights is closely related to several important clinical issues — participation in rehabilitation programming and readiness for supervised living in a specialized MICA residence.

  Most patients who attend rehabilitation programming, which is provided in a separate Central Rehabilitation building, must first achieve unescorted ground rights, as there are usually not sufficient staff available to provide escorts for all patients; and,

  In order to be placed in supervised residences, patients must have a track record of having been on unescorted grounds rights for two to three months without incident.

Thus, there is pressure to grant grounds privileges to facilitate eventual discharge. Without grounds rights, a patient's opportunity to attend programs needed for his treatment are limited, and his opportunity for eventual discharge to a supervised residential setting is also impaired.

Classification of Elopements

- The classification of incidents of patient elopements as LWOC (for non-dangerous patients) or Escape (for patients deemed a danger to self or others) from MPC appears to be based primarily on the patient's *recent* behavior *in the hospital*, rather than his *potential for violence*, as demonstrated by *past* behaviors or behavior *out of the hospital*.[2] (Report p.12)

ICM Notification and Actions Taken

- MPC staff made no efforts to reach the Intensive Case Manager (ICM) after any of R.H.'s four elopements (after the ICM was assigned on June 20, 1994), including his last LWOC of December 24, 1994, despite the fact that the ICM was listed as a Significant Contact on R.H.'s Face Sheet and is available through a 24-hour on-call system.
- The ICM failed to meet job performance expectations. He seemed unaware of R.H.'s prior history of violence against women and criminal activity, although he stated that he had received R.H.'s core history from his most recent admission, which mentioned these issues. The ICM treatment plan also did not address R.H.'s propensity to elope, although it was clearly a major obstacle to planning his eventual discharge to a supervised setting. (Report pp. 14-16)

Once the ICM became aware of R.H.'s Christmas Eve LWOC, he accessed the shelter data system and the HHC number (to determine whether R.H. was in a Health and Hospitals Corporation hospital) and checked with the police without success. He also attempted to contact the family. He conducted no physical search for the patient, as he explained that he only knew R.H. in the hospital and was not familiar with his whereabouts when in the community, if not staying in the shelter system.

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1 Edward P. Mulvey, *Assessing the Evidence of A Link Between Mental Illness and Violence, Hospital and Community Psychiatry*, Vol. 45 No. 7 p. 663-668, July 1994.

2 In the context of an involuntary psychiatric commitment made pursuant to the New York Criminal Procedure Law, §330.20, the New York Court of Appeals recently held a patient's risk of violent behavior or dangerousness may be shown "by presenting proof of a history of prior relapses into violent behavior, substance abuse or dangerous activities upon release or termination of psychiatric treatment, or upon evidence establishing that continued medication is necessary to control defendant's violent tendencies and that the defendant is likely not to comply with prescribed medication because of a prior history of noncompliance or because of threats of future noncompliance." *Matter of George L.*, __ N.Y.2d ____, 1995 W.L. 124619 at p. 6 (NY Ct. of App., March 23, 1995); *compare id.*, at p. 7 FN3; see also, *Matter of Selzer v. Hogue*, 187 A.D.2d 230 (2d Dept. 1994); *Matter of Francis S.*, 206 A.D.2d 4 (1st dept. 1994).

Corrective Actions

MPC has already initiated many corrective actions, particularly related to the assessment of patients' suitability for passes and facility security. These include:

- A Grounds Rights review process, which was under review at the time of R.H.'s arrest, was implemented immediately. An assessment is being completed for all current patients with grounds privileges and for all patients for whom this privilege is being considered. The form requires the psychiatrist to determine whether the patient has any history of dangerous behavior, address the patient's cognitive and functional deficits and note a patient's history of elopements, use of illicit drugs, and unsafe sexual behavior. If a psychiatrist determines that Grounds Rights are appropriate for the patient, he/she must write a rationale. Presently, all assessments are reviewed by the supervising psychiatrist. In the future, the Privilege Assessment Review Committee (PARC) will review all assessments of those patients with histories of criminal dangerousness.
- Staff received training on clinical issues related to violence from experts in the field. A committee of MPC staff is developing a dangerousness assessment tool. Revisions are being made in the process for notifying relevant parties when a patient has eloped. ICMs will be included.
- Chiefs of Service will now send ward staff, accompanied by MPC Safety Officers, to search for all patients who have eloped. Additional personnel have been assigned to the Discharge Tracking Team "to maintain follow-up efforts to locate missing patients who have not returned to the facility."
- Additional measures are being taken to ensure that essential case record information from prior treatment is secured.
- Facility security is being tightened. The Dunlop Building will be closed as a point of egress. All people will have to pass through a manned security post in the Meyer Building which will be equipped with a turnstile and an electronic card reading system. Patients as well as staff will be required to wear their picture IDs. Additional security measures are contained in MPC's Capital Construction Plan. A second secure recreation area is being built which will allow patients to enjoy the outdoors while minimizing the risk of escape.

The OMH must address treatment and discharge planning to the specific characteristics of patients who respond to psychotropic medication and structure when in institutions, but who often refuse supervised residential settings, fail to take medication, do not keep outpatient appointments, and, in relatively short order, decompensate.

The Executive Budget contains an appropriation of $2 million to improve security measures at state psychiatric hospitals in New York City.

Next Steps

These changes represent significant improvements in protecting patients and the community. The Commission believes that, in addition, the OMH must address treatment and discharge planning to the specific characteristics of patients like R.H. These patients respond to psychotropic medication and structure in their lives when in institutions. Often refusing supervised residential settings at discharge, these patients fail to take medication, do not keep outpatient appointments, and, in relatively short order, decompensate. With no supports, they become homeless. Many patients who fit this profile also use street drugs. The effect of the drugs on their personality coupled with the symptoms of untreated psychosis make these individuals unable to care for themselves and indifferent to the welfare of others. Within weeks or months, they are usually returned to the hospital for psychiatric evaluation.

Depending on the circumstances of admission, including whether the individual was involved in criminal activity, he will be classified as a civil or forensic patient. This classification determines to

some extent the level of security and the degree of review afforded to decisions regarding privileges and liberties, including grounds rights. In any case, either quite quickly or, in the case of forensic patients involved in misdemeanors and minor felonies, over a period of months, the cycle will begin again as patients are readied for discharge.

A rarely used provision of Mental Hygiene Law §29.15, enacted in 1975 (and which has existed in previous codifications of law since 1919) delineates conditions and procedures for the conditional release of patients. This law recognizes that the civil liberties of patients must be protected and patients must be released when they no longer require "active inpatient care and treatment." It also recognizes that some patients warrant a more restrictive placement and invests the directors of OMH facilities with the option of *conditional release* for patients whose clinical needs warrant it in the opinion of staff familiar with him/her. A voluntary patient may be conditionally released for 12 months and an involuntary patient for the remainder of the authorized retention period. Each conditionally released patient must be accompanied by a written service plan which must address supervision, medication, aftercare services, assistance in finding employment and residential services.

The Commission views this provision of law as a potentially useful tool which should be considered by OMH for patients:

(1) who have a history and current diagnosis of serious mental illness;
(2) who have engaged in repeated incidents of serious violent behavior;
(3) who have a concurrent diagnosis of alcohol and/or substance abuse; and
(4) who have previously been discharged from a psychiatric hospital, have failed to comply with their treatment plan, resumed their alcohol or substance abuse, and engaged in behavior which endangered themselves or others and led to their involuntary rehospitalization.

In contrast with the frequent poor discharge planning practices of psychiatric hospitals, documented in previous Commission studies,[3] the Commission views this law as reinforcing the legal obligation of a psychiatric hospital, with respect to the group of patients described above, to:

A rarely used provision of Mental Hygiene Law recognizes that some patients warrant a more restrictive placement and invests the directors of OMH facilities with the option of conditional release for patients whose clinical needs warrant it.

- engage in meaningful discharge planning with the patient, a representative selected by the patient and involved family members in developing a discharge plan that is responsive to the needs of the patient and in which the patient has had an active voice (MHL §29.15). Previous Commission studies have indicated that such discharge planning rarely occurs and that, consequently, patients have little investment in following their recommendations;
- provide assistance to the patient through assignment of an intensive case manager to assure that the services and supports planned for are in fact available and accessible in the community;
- closely monitor the implementation of the discharge plan and the well-being of the patient and to make changes in the plans and services to accommodate changing circumstances; and,
- intervene on a timely basis should the patient's psychiatric condition deteriorate due to noncompliance with the plan, abuse of alcohol or drugs, or other reasons. This intervention can include seeking to have the patient rehospitalized if his clinical condition requires inpatient care and treatment.

This law permits the OMH facility director to terminate the conditional release and order the involuntary patient returned to the facility at any time if the director believes the patient requires inpatient treatment. The law protects the rights of the individual by requiring notification to Mental

[3] *Discharge Practices of Inpatient Psychiatric Facilities*, August 1988; *Discharge Planning Practices of General Hospitals: Did Incentive Payments Improve Performance?*, April 1993

The Commission believes that use of the conditional release statute coupled with access to necessary community mental health and other services, and the support and monitoring provided by an Intensive Case Manager may be effective in stopping the cycle of decompensation leading often to aggressive behavior that characterizes many young male chemical-abusing patients.

Hygiene Legal Services (MHLS) when the provisions of this law are used. It also provides for hearings on the revocation of the conditional release at the request of the individual, relative or friend, or MHLS.

The Commission believes that use of the conditional release statute coupled with access to necessary community mental health and other services, and the support and monitoring provided by an Intensive Case Manager [who is responsible for 11 (soon to be 12) individuals] may be effective in stopping the cycle of decompensation leading often to aggressive behavior that characterizes many young male chemical-abusing patients. The Commission strongly recommends that OMH study the viability of using the provisions of this statute for these patients with a history of violence.

Recommendations

As noted, the OMH has taken many corrective actions to address the issues raised by the elopement of R.H. The Commission recommends the following corrective measures in addition.

Access to Information

- OMH should reexamine its policies and practices regarding the care and treatment of *all* patients with past histories of violent behavior and behavior which seriously endangers the patient. Such policies should ensure, without regard to their *current* legal status, that facilities have reliable and accurate information of such past behavior to be able to develop appropriate treatment plans and to make decisions regarding the conditions under which they can be granted liberty without undue risk of harm to themselves or others. At a minimum, records from all secure hospitalizations and the records of all CPL admissions should be obtained.
- OMH should consider expanding the scope of the DMHIS, a computerized information system, to include information about hospitalization in non-state facilities. Such admissions now account for most of the admissions in the mental health system and their inclusion would make the DMHIS a much more useful tool in providing information about relevant past history to assist in clinical decision-making. The DMHIS should also note if a patient is discharged from LWOC or Escape status. Such information would be helpful to clinical staff in future admissions.
- Information about the significance of being an outpatient of Central New York Psychiatric Center needs to be widely disseminated in the mental health system, as it would alert staff to a history of criminal, and possibly violent, behavior by the patient.
- Coordinators of the ICM programs need to ensure that ICMs are included as members of the treatment team and are advised of all significant events, including the granting of grounds privileges and leaves. Performance expectations for ICMs should be clarified and disseminated.

Clinical Evaluation and Judgment

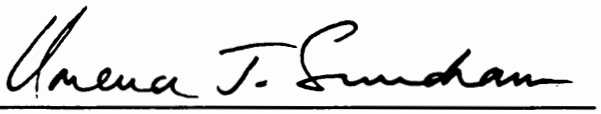
- The Commission reiterates the recommendation it made to OMH in 1987[4] that patients who have left the facility without consent should not be automatically discharged after the passage of a specific period of time, as is the current policy and practice. Rather, there should be an individualized clinical review of each case to determine

[4] *Investigation into Conditions at Creedmoor Psychiatric Center*, March 1987, p. 22.

appropriate follow-up actions to assure the well-being of the patient and the safety of the community.

- In making decisions about grounds rights and other leave privileges, facility staff should examine not only a risk of suicide and homicide, but more broadly examine the risk of danger to the patient and others, especially in light of known history of the patient during previous admissions. They should specifically review information about past hospitalizations in determining what safeguards, if any, are needed. Given the developing research findings about the association between mental illness, past histories of violence and substance abuse, OMH and MPC should reexamine policies and practices regarding the granting of grounds rights for patients with such histories. Specifically, OMH should consider the value of utilizing the conditional discharge provisions of MHL §29.15 to provide options for the supervision of such patients in the community.

This report represents the unanimous opinion of the members of the Commission.



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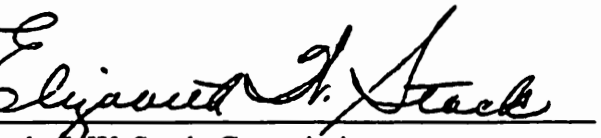
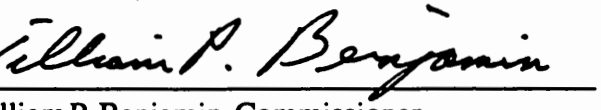


Elizabeth W. Stack, Commissioner



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Introduction

On January 4, 1995, R.H., a patient of Manhattan Psychiatric Center (MPC) who had eloped from the facility on Christmas Eve, was arrested for allegedly pushing Soon Sin, a 63 year old Korean grandmother, in front of an oncoming subway train to her death at the 34th Street station of the F line in New York City. The incident prompted questions of how R.H., or anyone with his history of mental illness coupled with several previous violent acts, could be allowed off the ward unescorted so he could "get away and do this." Questions were also raised about the assessment by the patient's psychiatrist that Mr. H. was not considered dangerous at the time that he left the facility, although he had been noted as dangerous when he was involuntarily committed from the shelters during March 1994. His leaving was classified as a "Leave Without Consent" (LWOC), rather than an "Escape," which is reserved for patients who are considered to be homicidal or suicidal, or who are under a Criminal Procedure Law (CPL) commitment.

As this report will show, miscalculations about the dangerousness of Mr. H. did not begin in 1994 and were not confined to MPC; they had been occurring for nearly 20 years.

Investigative Actions

In an effort to understand who Mr. H. is, his social, psychiatric and criminal history, his lifestyle when not in the hospital or incarcerated, and the supports available to him, Commission staff spoke with a variety of individuals who had contact with Mr. H. in various roles, read treatment records from several sources and spoke to those individuals at MPC and the OMH New York City Regional Office (NYCRO) who were also trying to understand how the tragedy of January 4, 1995 had come to pass.

Two Commission staff visited MPC on January 9-10, 1995. There they met with the Director of Quality Assurance at MPC, the facility Principal Investigator, the Chief of Service of the unit where Mr. H. had been a patient, and his treating psychiatrist. Commission staff reviewed Mr. H.'s clinical records for the four hospitalizations he had at MPC from February 1, 1984 until the time of the incident under review, and reviewed admission and discharge summaries of his earlier hospitalizations at MPC (see Appendix A, Movement History). They also reviewed all incident reports for Mr. H. from August 1985 through January 4, 1995 and the ward communication logs for Mr. H.'s two hospitalizations at MPC during 1994. In addition, Commission staff reviewed statements of staff gathered by the facility investigator, and were kept apprised of her ongoing efforts.

Following the Commission's on-site review, direct and telephone conversations were conducted with members of the NYCRO staff. These individuals supplied the Commission with a summary of Mr. H.'s treatment at Mid-Hudson Psychiatric Center (a forensic psychiatric facility run by the OMH) supplied by the OMH Bureau of Forensic Services and Bronx PC's summary of his confinement at Clinton Correctional Facility. Bronx PC also provided admission and discharge information regarding Mr. H.'s 1990 hospitalization there after his release from the Clinton Correctional Facility. Commission staff interviewed the Director of the OMH Intensive Case Management (ICM) Program, the Coordinator/Supervisor of the Homeless Shelter ICM team, and Mr. H.'s Intensive Case Manager (ICM) who supplied information about the Intensive Case Management services provided to Mr. H. and other homeless individuals. In addition CQC staff reviewed the ICM policy manual and Mr. H.'s ICM record. Finally, a Commission investigator contacted the McCauley Mission where Mr. H. had been known over the years and spoke with staff who had facilitated his March 1994 readmission to MPC.

Patient Profile

Family History

R.H., Jr. was born in New York City on May 27, 1952 (42 years old) and raised in Brooklyn, the third of eight children (5 girls, 3 boys). His father was a motorman, and his mother worked for a city governmental agency. Mr. H. graduated from high school and attended City College of New York for two years, reportedly studying Chemistry and Sociology. In 1972, at age 20 he married and had a son. He separated five years later and reportedly has not seen them since. His psychiatric records detail a work history from 1972-1975 in jobs lasting from three months to more than a year as a security guard, maintenance helper, insurance company employee, supervisor in a button factory, and children's camp counselor. He also reportedly worked as a construction worker in 1983 and 1984, and at times he has received SSI, a federal grant available to persons who are unable to engage in "substantial gainful activity" as a result of disability.

Mr. H. lived in several OMH certified residences, when not hospitalized, between 1983 and 1987, but has apparently lived primarily in shelters or possibly in the streets in the last few years. Little is actually known about Mr. H.'s whereabouts from June 1990 - January 1994.

Psychiatric History

Mr. H.'s psychiatric history, as detailed on Appendix A, Movement History, began at age 19 in 1971 at Brookdale Hospital, where he reportedly was treated for depression. According to material from his earliest admission to MPC in 1980, Mr. H. attributes his early illnesses with having drunk something laced with LSD at a college party. Although he had several additional brief stays at Brookdale, St. Vincent's (year unknown) and St. Luke's, the majority of Mr. H.'s hospitalizations were within the state mental health system at Kingsboro PC (twice in 1976-78 for a total of 15 months), Manhattan PC (five inpatient stays between 1982-95 ranging from one month to over two and one-half years), Bronx PC (a single six month inpatient stay in 1990), and Mid-Hudson PC (a six week stay in 1988 after he was found unfit to stand trial because of his psychiatric condition on charges of assault and criminal possession of a weapon).

There was no record that Mr. H. had received any outpatient treatment during the last seven years, and in records of his recent hospitalizations he was described as non-compliant with aftercare.

Mr. H.'s diagnosis has invariably been listed as Schizophrenia, Chronic Paranoid or Disorganized type, with Substance Abuse noted on Axis I or Axis II. At Mid-Hudson PC he was diagnosed as Unspecified Psychoactive Substance Delusional Disorder and Personality Disorder not otherwise specified (Antisocial Trait). He also has an Axis III diagnosis of Hypertension for which he received medication during his most recent hospitalization.

By history, Mr. H. generally compensated fairly rapidly and was compliant in taking the psychotropic medications prescribed for him while an inpatient. He was treated with Lithium at MPC for a year from 1984-85 and with a variety of neuroleptic medications, including Thorazine and Haldol during his other hospitalizations. However, since 1983 at MPC he has usually been treated successfully with varying dosages of Navane. Inpatient records indicate that Mr. H. was known to MPC's Westside Clinic for a long time, and his compliance with aftercare during the early years was erratic at best. There was no record that Mr. H. had received any outpatient treatment during the last seven years, and in records of his recent hospitalizations he was described as non-compliant with aftercare.

Mr. H.'s hospitalizations at MPC, as well as his stay at Bronx PC, were generally marked by frequent LWOCs usually for short periods of time a day or two during which he would seek drugs, and generally return on his own.

Substance Abuse History

Various assessments in his inpatient records reveal that Mr. H. began drinking at age 16 and began using drugs four to five years later. Since that time he has used cocaine, crack, heroin, marijuana, angel dust, and quaaludes. Mr. H.'s earlier psychiatric hospitalizations appear to have been secondary to drug induced behavior. On transfer to MPC from Maimonides Hospital on February 11, 1980, where he had been hospitalized for one week after breaking into a car in an agitated state, he displayed no gross evidence of acute psychosis, and the episode was believed to be drug-induced. During his MPC hospitalizations, records periodically note on-grounds use of drugs, despite his enrollment in substance abuse therapy groups throughout his hospitalizations. During his most recent stay at MPC prior to his escape on Christmas Eve, Mr. H. tested High Positive for marijuana on several occasions while on grounds at MPC and following some of his elopements.

History of LWOC and Other Incidents While Hospitalized

Mr. H.'s hospitalizations at MPC, as well as his stay at Bronx PC, were generally marked by frequent LWOCs usually for short periods of time—a day or two—during which he would seek drugs, and generally return on his own. During his earlier hospitalizations at MPC Mr. H. was involved in a few incidents of violent acting-out behavior during which he cut a male patient with his cross for reportedly making sexual advances (1985), and kicked a peer in the face while in the Meyer Building lobby, causing him multiple injuries (1986). However, the majority of incident reports (11 of 18) at MPC involving Mr. H. in the last ten years documented his going LWOC. Invariably, he was noted to not be homicidal or suicidal and was not considered dangerous.

His treatment was similar at Bronx PC in 1990. Mr. H. was transferred directly to Bronx PC from an 18 month incarceration in prison for slashing a man's face with a razor. His incarceration had followed six weeks of treatment at Mid-Hudson PC. Within a month, clinical staff at Bronx PC found him not to be a danger to others and he was converted to voluntary status. He was later granted grounds and then overnight passes, despite multiple LWOC's and illicit drug use, verified by positive urine drug screens. He was discharged from LWOC six months after his admission and noted not to be homicidal or suicidal.

Criminal Justice History

As noted on Appendix A, Movement History, Mr. H. has a lengthy arrest and conviction record dating back to 1974. Prior to the current arrest for homicide, he was arrested twelve times and convicted ten times for a variety of felonies and misdemeanors including arson, criminal possession of a weapon, petty larceny, assault and trespassing. The most serious incident involved the 1988 slashing on the subway of a man's face who had asked him for change, which precipitated his stay at Mid-Hudson PC and subsequent incarceration for one and one-half years of a three year sentence for Assault in the 2nd degree at Clinton Correctional Facility. Mr. H. decompensated the day before his planned release on parole in May 1990, acting bizarrely and disorganized, complaining that he had the wrong color pants and did not want to be released. This precipitated a delay of three weeks in his release and resulted in his being transferred to Bronx PC on June 20, 1990 on a two physicians' certificate. Previously, in November 1983, he was charged with misdemeanor Assault in the 3rd degree for striking a woman on the street in the head and inflicting a concussion. He was found not fit to proceed and, in accordance with the Criminal Procedure Law (730.40), the charge was dismissed and Mr. H. was immediately transferred to MPC on February 1, 1984 for treatment.

Mr. H. has a lengthy arrest and conviction record dating back to 1974. Prior to the current arrest for homicide, he was arrested twelve times and convicted ten times for a variety of felonies and misdemeanors including arson, criminal possession of a weapon, petty larceny, assault and trespassing.

Less than a month later, after review by the facility's Forensic Committee, he was converted to civil voluntary status, was granted unescorted privileges, and was discharged a month later. As a rule, Mr. H. pled guilty to less serious charges, and with the exception of the one and a half years he served following the assault noted above, he had spent little more than a total of eight months in the custody of the correctional facilities, despite his multiple arrests and convictions.

Most Recent Hospitalizations

March 9 - April 15, 1994

Mr. H. was screened at the Volunteers of America's Charles Gay Men's Shelter on Wards Island, where he had been staying for the previous month, by OMH's Shelter Assessment and Referral Program (SHARP) ICM team because he was laughing inappropriately and hearing voices telling him to hurt people. After evaluation at Metropolitan Hospital, Mr. H. was committed involuntarily to MPC.

The staff members who completed the assessments at MPC following this admission, most notably the part-time social worker whose task is to prepare Core Histories for newly-admitted patients, had access to and included information about Mr. H.'s prior history at MPC some seven years earlier, in 1987. In addition, the Department of Mental Hygiene Information System (DMHIS) printout, which details the admission and discharge dates of all inpatient and outpatient contacts in OMH-operated facilities and the individual's legal status (but does not indicate if the patient was discharged from LWOC or Escape), was available on admission in the patient's record. This printout reflected Mr. H.'s history of CPL admissions to Mid-Hudson in 1988, "outpatient" treatment at Central New York Psychiatric Center in 1988-89,[5] and a CPL stay at MPC in February 1984. In fact, records from the MPC CPL admission of February 1, 1984 to March 29, 1984, after Mr. H. had assaulted a woman on the street, included the legal papers detailing the charges against him, along with a computer printout of his criminal history or "rap sheet" reflecting his history of arrests and convictions from 1974 to 1983. However, the social worker completing the initial Core History during this spring 1994 admission reportedly informed the facility investigator that he had not seen the records of Mr. H.'s MPC CPL admission. Nevertheless, the Core History that he prepared noted a history of multiple incarcerations at Riker's Island for assault, car theft, etc., and noted his history of treatment at Mid-Hudson and Central New York PCs. None of the assessments, however, reflected any awareness by MPC staff that Mr. H. had slashed a man's face in 1988 with a razor on the subway or that his outpatient treatment at Central New York PC indicated that he had received mental health services while in prison for the crime. There was also no mention, or particular attention paid to the fact that he had been a CPL patient at MPC and Mid-Hudson PC. Significantly, no efforts were made to request the records or to gather more information about these stays.

Mr. H. was diagnosed as Axis I: Schizophrenia, Chronic, Disorganized type. Cocaine and Alcohol abuse; II: Deferred; III: Hypertension. He was placed on Navane 40 mg. per day. He did not present as a management problem on the ward, and after a few weeks, signs of his psychosis, including auditory hallucinations, were no longer apparent. Mr. H. was eager to leave the hospital, was compliant with

[5] Any prisoner receiving psychiatric services at an OMH satellite clinic in the prison is considered an outpatient of Central New York PC, the state's inpatient psychiatric facility for prisoners. This designation facilitates the tracking of these individuals to promote continuity of care.

Mr. H.'s history of violence is not specifically addressed in the treatment plan and there is no documentation to suggest that it was the subject of discussions/therapy with him. No extra precautions were taken in granting him grounds privileges.

medications and ward routine, and repeatedly requested his Honor Card so he could leave the ward and "go to Rehab." Although his treatment plan attributes his history of hospitalizations and incarcerations to "auditory hallucinations, (and) *bizarre and violent behavior*" and notes these as *risk factors*, Mr. H.'s history of violence is not specifically addressed in the plan and there is no documentation to suggest that it was the subject of discussions/therapy with him. No extra precautions were taken in granting him grounds privileges.

During this hospitalization, Mr. H. was not involved in any untoward incidents and was not placed in seclusion or given PRN/Stat medications. On April 6, 1994, just short of a month after he was admitted, Mr. H. was converted to voluntary legal status, referred to Rehab and was granted unescorted privileges. He also signed a consent to be a participant in a research protocol for use of an experimental drug, and was to be transferred to the Research Unit. On April 8, 1994, Mr. H. did not return from grounds privileges.

The incident report stated that Mr. H. had recompensated and was "not a danger to himself or others," and his elopement was therefore classified as an LWOC, despite his known history of violence when he is not treated, use of street drugs and decompensations. On April 11, 1994, the ward social worker was told by the McCauley Mission staff that they had seen Mr. H. and he seemed agitated. The pastor agreed to ask Mr. H. whether he would return to the facility, but no actions were taken by MPC at that time to have him return. He was discharged April 15, 1994 while still on LWOC status. In fact, the discharge summary on April 26, 1994 noted "whereabouts unknown."

May 23, 1994 - January 5, 1995

On May 20, 1994, approximately six weeks after his discharge from MPC on LWOC status, Mr. H., who had been staying intermittently at the McCauley Mission, was brought to Bellevue Hospital Center by a social worker from the Mission's Care for the Homeless program (see Appendix A, Movement History), reportedly in response to the prior request of his MPC social worker. At the Mission, Mr. H. was noted to be psychotic but reportedly did not appear dangerous to those around him. At Bellevue he was noted to be "floridly psychotic, yelling and gesticulating." He requested his return to MPC and was transferred there as a *voluntary* patient.

On admission to the same ward he had left just weeks earlier, his Core History was briefly updated, with the Core History from his prior admission forming the bulk of the information provided. Most notably, under the legal history section which requests information on "arrests and circumstances; current pending charges; convictions; periods of incarceration, probation, parole," it was written during both 1994 admissions that, in addition to his history of multiple incarcerations at Riker's Island for Class A misdemeanors and Class D felonies for assault, car theft, trespassing, larceny and possession of stolen property, as well as drugs, "*there are no pending charges at this time.*" When interrogated by the facility investigator, the social worker who completed the Core History indicated that "this statement was based on the referring materials available at the time of the March 1994 admission."

Although treated by the same team, "Risk Factors" identified in the assessments this time did *not* include R.H.'s history of violent behavior, and the treatment plan, while targeting his psychotic symptoms, substance abuse, non-compliance and homelessness, and history of elopements, did not address his history of violence and incarcerations, or their relationship to his other problems.

Mr. H. was treated with Navane 20 mg twice daily which was later increased to 25 mg during October 1994, following several days of agitated and threatening behavior to staff and other patients requiring the rare use of PRN medication and seclusion. His drug screening was negative at this

Risk Factors identified in the assessments did *not* include R.H.'s history of violent behavior, and the treatment plan, while targeting his psychotic symptoms, substance abuse, non-compliance and homelessness, and history of elopements, did not address his history of violence and incarcerations, or their relationship to his other problems.

time. As during prior stays, Mr. H. compensated rapidly and started pressuring the staff for an honor card. He was granted escorted grounds privileges, Level II (the right to attend off-ward activities with a staff escort, typically with a group of patients) 11 days after admission. Approximately three weeks later, he received unescorted privileges, Level III. A note in Mr. H.'s Comprehensive Treatment Plan of June 2, 1994, explicitly states the team's assessment of Mr. H.'s problems. The absence of any mention of his history of violent and criminal behavior is indicative of the way the mental health system had assessed and treated him for the previous 20 years: "The patient has demonstrated to us a pattern of dealing with his illness. He quickly pressures the staff for an "honor card" and goes LWOC. He returns to live at the shelter, starts drugs/stops meds. . .and has recurring episodes of illness which result in the need for rehospitalization. *Is there something we can do to stop this cycle? (CR/ICM/ REHAB/MICA)????"*

During this stay, on June 20, 1994 Mr. H. was assigned an Intensive Case Manager (ICM) from the OMH Shelter ICM Program, which operates out of the New York City OMH Regional Office. The ICM was listed in the treatment record as a significant contact. Mr. H. was transferred to the Community Prep Unit, an open ward, on July 5, 1994 and proceeded to go LWOC on July 15 for one day, although there were *no notes in the record* indicating he returned or of any actions taken upon his return. There was also no indication that his ICM was contacted, and the ICM informed CQC that he was never contacted by MPC staff after any of Mr.H.'s four elopements.

Mr. H. remained on the open unit with no change in privileges, and on July 20 he went LWOC again, this time for six days, until the ICM accidentally met him on 125th Street on July 26 while the ICM was going to MPC to visit him. The ICM brought him back to the hospital. At the time of his return, Mr. H. was typically dishevelled, confused, psychotic, and had been abusing substances, but was not aggressive towards his ICM or others. The results of drug screens taken *prior to and after his first LWOC* were returned while Mr. H. was away for these six days and showed High Positive indications for marijuana. Mr. H. was transferred to the MICA (mentally ill chemical abuser) Unit on August 17, 1994. He ran away from staff while on an escorted fresh air break on August 30 and did not return for two days.

The incident report and the IRC designated this an "escape" consistent with facility practice initiated in 1993 for patients who elope from escorted privileges—a practice developed with the understanding that if a patient had not progressed past escorted privileges, he was not sufficiently compensated to be in the community without posing a likely threat to himself or to others. Nonetheless, the physician noted that Mr. H. was not homicidal or suicidal, and ward staff referred to his leave as LWOC on the shift log and in the record. When he returned his urine toxicology report was again High Positive for marijuana.

On October 12, 1994, Mr. H. was threatening to staff and patients and clinical staff ordered the rare use of seclusion and PRN medication. Following this incident he did not achieve Level II, escorted privileges, until November 9, 1994, and he was granted unescorted grounds rights on November 23, 1994, when improvement in his clinical status following an increase in his Navane during October was noted. Just prior to his Christmas Eve elopement it was noted that he had shown insight into his illness and its connection with his substance abuse.

Again, as during his spring 1994 admission and reflected in the note quoted earlier, the treatment team, and in this case Mr. H., were making the connection between his hospitalizations and his substance abuse. No one was making the connection yet with his history of violent and criminal

behavior. This most likely is the case because Mr. H. was only rarely aggressive on the unit, and as noted earlier in this report, although much information was known and additional information could easily have been gathered from other OMH facilities such as Central New York and Mid-Hudson Psychiatric Centers, no one had put the information together so that the team could see the whole picture. Instead, staff were looking at snapshots—repeated admissions and repeatedly positive drug screens. It is clear that despite the information that was available to them, Mr. H.'s treatment team did not view him as a potentially dangerous person.

Mr. H. eloped from grounds pass at 6 p.m. on December 24, 1994. A telegram was sent to his family, which was lost in transit and resent after Mr. H.'s arrest, but no one contacted his ICM. Mr. H. was discharged from MPC on January 5, 1995, following his arrest.

Elopement Policies, Procedures and Practice

MPC's policy for Ground Rights was revised during October 1993 following the Commission's review of several problematic LWOCs. The revised policy asks the psychiatrist to evaluate the patient's ability to function safely on the facility grounds without supervision in deciding if ground rights should be designated as Restricted (patient confined to the ward), Escorted or Unescorted. The policy directs the psychiatrist to conduct an ongoing clinical assessment which should include eight areas of consideration: the patient's physical condition and psychopathology; whether the patient is suicidal or homicidal, or *otherwise likely to endanger self or others*; whether the patient has the capacity to make appropriate decisions about (a) *leaving or remaining on the grounds*, (b) *using or abstaining from drugs or alcohol*, (c) sexual activity, (d) *returning to the ward at the appropriate time*, and other critical choices which may arise; and (e) whether there is enough information available to make reasonable decisions about all of the areas being assessed.

The policy requires that all patients have a doctor's order addressing privilege level and that orders for patients who are restricted to the ward are to be reviewed every day for the first week and weekly thereafter. The policy also indicates that if grounds rights are ordered for a patient who has had them previously but has not exercised them appropriately, a progress note from the psychiatrist must document the changes in the patient's behavior and/or condition which support the decision to grant grounds rights again.

Notably, this policy, which was in effect at the time of the incident under review, failed to direct the psychiatrist to include in his/her assessment the patient's *history of violence or otherwise problematic behavior in the community*, and offered no guidance on how this information should be weighed in granting grounds privileges. An assessment form with accompanying guidelines to assist psychiatrists in making decisions regarding the granting of grounds rights (which included consideration of the patient's prior history) was being studied at the time of Mr. H.'s arrest. This policy has since been implemented at MPC and will be discussed under corrective actions, below.

During 1994, 28 percent of all LWOCs (158/569) and 37 per cent of all escapes (97/264) from MPC were from the MICA unit which holds 14% of MPC's patients.

It is clear from a review of Mr. H.'s record and discussion with his psychiatrist that *recent* behavior is most critical in granting grounds rights to non-CPL patients. Recent behavior was generally defined as behavior evidenced in the most recent couple of weeks. In Mr. H.'s case, he went LWOC on July 15 and again on July 20 without any change is his privilege level. In fact, when Mr. H. eloped on July 20 for *six* days until returned by his ICM, the psychiatrist's note after his return indicated that he had returned on each occasion after *one* day. This is consistent with what appears to be the perception at MPC that LWOCs are commonplace, particularly among MICA patients, and most return within a day or so. During 1994, 28 percent of all LWOCs (158/569) and 37 per cent of all escapes (97/264) from MPC were from the MICA unit which holds 14% of MPC's patients. In addition, 18 percent (102/569) and 20 percent (52/264) of LWOCs and escapes, respectively, were from the Admissions Unit, from which the MICA patients are generally referred.

It should be noted that another policy, "Access to Off-Ward Environments for Patients on Locked Wards," effective July 1994, details MPC's responsibility in response to the court's decision in the *Jean D.*[6] case. The decision requires that by December 1994, 95 percent of patients on locked wards,

[6] *Jean D. et al. v. Cuomo et al.*, 90 Civ. 0861 (SS) (S.D.N.Y. 1993).

Patients who are placed on Escape status are those considered *likely to be* dangerous to themselves or others; unable to care for self and endangered; criminally committed under a court order pursuant to CPL law; or have criminal charges pending in court with a warrant for their arrest after release from the facility.

who do not have access to the grounds, with few delineated exceptions, shall go outdoors for approximately one hour at least 16 days a month, including two weekend days on separate weekends during the month. Referred to in treatment records as FAB (fresh air breaks), this requirement was cited by staff as responsible for some elopements as they felt increased pressure to get patients off the ward yet had insufficient staff to escort patients individually, but only in small groups. Thus, if a patient left the group, staff could not leave the group to dissuade the eloping patient.[7]

MPC's policies for Incident Reporting and Investigation and Missing Patient Incidents have not been revised since 1987. According to the policies, patients who are placed on Escape status are those considered *likely to be* dangerous to themselves or others; unable to care for self and endangered; criminally committed under a court order pursuant to CPL law; or have criminal charges pending in court with a warrant for their arrest after release from the facility. Those patients not meeting any of these criterion are classified as LWOC. The Missing Patient Incident Policy adequately delineates the responsibilities of all involved parties for reporting and proper notification of the incident, including family members, the police, and individuals who may be at risk.

A review of the policy reveals several problematic provisions: there is an apparent discrepancy in definitions for the assessment of dangerousness and thus classification as an escape. The physician is initially directed to classify the incident as an escape if the patient is *likely* to be dangerous. However, later in the policy under "Procedure" the physician is directed to assess "whether or not the patient *is* dangerous to self or others." This distinction is not hair-splitting; it is the difference between making a judgement based solely on an individual's behavior at the moment as opposed to a judgement which includes consideration and weighing of past behavior as a predictor of future likely behavior. Again, it is the difference between looking at one piece of the picture and attempting to see, to the best of one's ability, the whole—current and past relevant information.

The current policies for Incident Reporting and Investigation and Missing Patient Incidents developed in 1987 also do not require that ICMs be notified of serious incidents, which may include LWOCs and escapes. No such notification was made to Mr. H.'s ICM during any of the elopements, despite the fact that from 1992-1994, the Social Work Department had generated several memos to staff informing them of the need to advise the ICM of all significant events in the patient's treatment, including LWOCs.

Although the Missing Patient Incident policy calls for the discharge of all LWOC patients who were on voluntary status within 72 hours, Commission staff found no evidence in this case that the discharge was effected. Mr. H. was not discharged when he failed to return for six days in July 1994 nor after his final elopement on December 24, 1994. In the latter instance, he was not discharged until news of his arrest on January 5, 1995. In addition, we are aware that in response to a prior CQC case during 1993, in which a voluntary patient went LWOC while being escorted and subsequently stabbed a toddler in the head with a pen, all elopements from staff escort were to be classified as Escapes. However, although in practice these incidents are officially classified as Escapes, this had not yet been incorporated into the MPC policy, which is currently being revised.

[7] 1994 OMH statistics do not show a proportional increase in the number of elopements when compared with the percentage of escorted patients participating in fresh air breaks. The percent of escorted patients participating in fresh air breaks increased from 25% for the first quarter of 1994 to 85% for the final quarter—a 240% increase. There were 66 elopements in the first quarter of 1994 and 72 in the final quarter, an increase of 9%.

In addition, although all of the elopements from escort are officially classified as Escapes on the incident report by the Chief of Service and by the IRC, it doesn't appear that they are actually regarded as Escapes on the unit or by the Police. For example, when Mr. H. ran away from staff on August 30, the physician completing the incident reports noted that the patient "was not homicidal or suicidal," and the change of shift logs when he left and returned referred to his absence as LWOC. The Commission was further apprised by the facility that although Safety hand-delivers all Escape reports to the 25th Precinct immediately, (LWOC reports are delivered once daily), if the patient is voluntary or is not noted to be dangerous, reportedly little will generally be done by the police to search for the patient.

Granting of Grounds Rights and Classification of Mr. H's Elopements

As noted above, the Treatment Team was aware that Mr. H. had a criminal history of multiple arrests and incarcerations from 1974-1983, that he had a history of assaults, and elopements. It was also apparent that his assaults generally occurred when he was not receiving treatment and was abusing drugs, which he invariably did during his LWOCs. Noted in the recent record was his prior assault of a woman on the subway with an umbrella prior to his most lengthy psychiatric stay of July 1984 to March 1987. While his CPL admission of February 1984 for assaulting a woman on the street in November 1993 was not referenced in the Core History, the record of that hospitalization was available at MPC.

Although the information was in the record, it clearly did not occur to staff, or appear to be particularly relevant to them at the time, that Mr. H's two CPL admissions were most likely secondary to serious criminal acts information which might have signalled to his potential for violence. No efforts were made to acquire material from Mid-Hudson Psychiatric Center, or from his outpatient treatment at Central New York, and MPC staff were divided as to whose job that was.

The social worker on the admitting unit during both of Mr. H.'s 1994 admissions informed the facility investigator that "the direction of Mr. H.'s treatment and treatment goals was *fairly straightforward.* There was no indication from the treatment team that there was a need for records of previous hospitalizations in other facilities to formulate this plan." Although, Mr. H.'s treating psychiatrist at the time of his final elopement was aware that the listing of Central New York PC outpatient status in Mr. H.'s record meant he had been receiving mental health services within the prison system, some MPC administrators, including the Director for Quality Assurance, as well as staff who completed assessments, seemed unaware of this fact, as they did not connect this status with a sentence to prison.

The psychiatrist explained the need to place patients on unescorted privileges because they generally need to demonstrate that they have successfully handled this level of freedom for two to three months before they will be accepted into a supervised living arrangement.

Mr. H.'s treating psychiatrist informed CQC that access to outside records was particularly difficult and that "we usually don't ask for them." She did not view it as a facility policy and noted that the patient loads are so large that getting patient consents and mailing them out was time-consuming. (Consent forms are not required when an OMH facility requests patient records from another OMH facility). When Commission staff questioned the physician about Mr. H.'s prior CPL admissions in 1984 and 1988, she viewed these as "in the past, not important." She also indicated that when she was evaluating a patient's dangerousness to himself or others for the granting of grounds rights and after elopements she generally looked at the patient's behavior over the last two months, not as far back as 1988 or 1984. The psychiatrist also spoke of the need to place patients on unescorted privileges because they generally need to demonstrate that they have successfully handled this level of freedom for two to three months before they will be accepted into a supervised living arrangement.

It appears that MPC staff had sufficient information available to them to make reasonable decisions about whether to grant Mr. H. unescorted grounds privileges and to accurately assess whether he presented a danger to others when he eloped from the facility. Statements attributed to OMH officials have been reported in the press to the effect that had the facility been provided with an up-to-date "rap sheet" on Mr. H. detailing his stay in

prison in 1988-89 for assault in the 2nd degree, or more specifically, had the facility known that he had cut a man's face with a razor on the subway after the man approached him for change, Mr. H. would never have been granted unescorted grounds privileges, and his elopements would have been classified as Escapes rather than LWOCs. However, based on the information available, including the CQC interview with his treating psychiatrist, and the policies in place at MPC for Ground Rights and Missing Patient Incidents at the time, as discussed above, it is most likely that this information would not have affected either of these two significant decisions.

The assessment of Mr. H as not likely to harm himself or others was not limited to MPC. Bronx PC had previously made a similar assessment. On June 20, 1990, the day Mr. H. was transferred to Bronx PC on a 2 PC from Clinton Correctional Facility after serving one and a half years on a conviction for assault for cutting a man's face with a razor on the subway, it was noted by a psychiatric consultant from the Secure Care Unit that "his agitation presents *no particular danger for violent acting out*," and he was found appropriate for an admissions ward rather than Secure Care. Mr. H. was converted to Voluntary status one month later on July 23, 1990 and discharged on December 20, 1990 from LWOC of December 1, 1990 after he did not return from honor card privileges. During the six months he was a patient at Bronx PC, he was granted several unescorted leaves to visit his parents. Random drug tests during this hospitalization were sometimes positive for drug use. Mr. H was determined to "no longer be dangerous to himself or others" at the time of his elopement.

These two decisions—to grant voluntary status soon after his admission and to grant unescorted leave—were made by the treatment team at Bronx PC with the full knowledge of Mr. H.'s prior psychiatric, substance abuse and criminal history, and immediately following his incarceration for a serious crime. This suggests that nearly exclusive reliance on current behavior and proximate past history of a month or two, (e.g., no involvement in incidents, compliance with medication, participation in activities, and no need for the use of restraint or seclusion or additional medication) is common practice and not isolated to a particular facility, psychiatrist, or unit.

Nearly exclusive reliance on current behavior and proximate past history of a month or two is common practice and not isolated to a particular facility, psychiatrist, or unit.

As obtained from OMH Forensic Services and publicized in the media, at the time of Mr. H.'s arrest, there was an outstanding bench warrant from his April 1993 arrest on charges of criminal possession of a weapon, menacing, and disorderly conduct. It was inaccurately noted in Mr. H.'s Core History for his recent admission that there were no criminal charges outstanding against him, yet it remains unclear if MPC would have taken any actions had they known. The issue of learning about outstanding warrants had come up in prior CQC cases at MPC in 1993, to be discussed below. The Commission was informed that the question of whether this information is available to OMH and, if so, how to obtain it, was forwarded to OMH Counsel last year and should be resolved shortly.

Actions Taken Following LWOC of December 24, 1994

Manhattan PC

Consistent with facility policy, when Mr. H. left the ward at 6 p.m. on Christmas Eve for a fresh air break and did not return by 10 p.m. he was classified as LWOC. Ward staff notified the Safety Department and attempted to call Mr. H.'s mother, but the number that was listed in his record was no longer the correct number for his family. The number was reportedly changed years earlier and not given to the patient. Nonetheless, many people during Mr. H's recent hospitalizations, including his ICM, called this number and reportedly left messages for his mother that would never be received. This supports newspaper accounts that the family denied that the hospital or the ICM ever left messages on their

The Intensive Case Management (ICM) program addresses the needs of people with severe and persistent mental illnesses with marked functional impairments which have not been successfully addressed by existing programs.

machine. On the night Mr. H. went LWOC, the Ward Charge sent a telegram to the family at his mother's Brooklyn address and documented this in the record. Unfortunately, after Mr. H. was arrested it was learned that the telegram was lost in transit "due to circumstances beyond our control" and was resent on January 5, 1995 and received by the family, after Mr. H.'s arrest. MPC's Safety Department was notified and dropped the LWOC report off at the 25th Precinct during the early morning hours of December 25, 1994. As noted earlier, as a report of an LWOC patient who was on voluntary status and "not considered dangerous," these notifications reportedly get little attention from the police.

Mr. H.'s social worker on the MICA unit returned to work on Tuesday, December 27, three days following Mr. H.'s LWOC. In her interrogation by the facility, she acknowledged not reading the change of shift log when she came back to work, and she appeared to be unaware that Mr. H. had eloped until December 28, 1994. She acknowledged not contacting the ICM about the elopement, but denied it was her responsibility. In addition, the Chief of Service was on vacation until December 29, 1994 and did not review the incident report of Mr. H.'s elopement until January 3, 1995.

Based on Commission interviews with the ICM, and his supervisor, the Shelter ICM Coordinator, the ICM was not notified of Mr. H.'s LWOC by any MPC staff, although he was listed as a significant contact person. Although MPC social work staff have been trained on the importance of the role of the ICM and had been directed to contact the ICM following all LWOCs, it does not appear that there are any policies directing ward staff to include the ICM in their initial notifications following significant events, although it is reportedly accepted practice to contact those community people who are closely involved in the patient's treatment.

It is ironic that after each of Mr. H's LWOCs ward staff immediately attempted to reach the patient's family, despite the fact that they had not been involved in his treatment and had not responded to MPC's attempts to invite them to be involved during his last two hospital stays. On the other hand, the patient's ICM had visited him every week since he was assigned to Mr. H and was listed as a "Significant Contact," but was never notified after any of his four elopements. It should also be noted that after each elopement the ICM spoke to unit staff about the oversight and reminded them of the need to contact him by beeper or the on-call ICM number, available 24 hours a day, to no avail. The ICM did not learn of the elopement until he came to visit Mr. H. on December 28, 1994, and noticed in Mr. H.'s chart that he had gone LWOC four days earlier.

The ICM

New York State's Intensive Case Management (ICM) program was initiated by the State Office of Mental Health in 1988 in partnership with State and local governmental agencies to address the needs of people with severe and persistent mental illnesses marked by impairment in several essential functions which had not been successfully addressed by existing programs. Candidates include individuals who frequently use emergency rooms, acute inpatient psychiatric units, and state psychiatric centers; individuals with multiple disabilities, such as drug and alcohol abuse, and who may be known to the criminal justice system; people who are both mentally ill and homeless; and seriously mentally ill children and adolescents. Through a combination of advocacy, self-help, coordination, and service delivery, the ICM attempts to prevent these individuals, who are often viewed as resistant and "untreatable," from falling through the cracks of the bureaucracies in the service delivery system. The intensive nature of the program is defined by the manner in which the services are available to clients: 24 hours a day, 365 days a year, through experienced case workers with a caseload of 11 clients (soon to be 12), who visit the clients wherever they are, at least once a week.

In response to growing problems with "special populations," separate ICM programs have been developed for the mentally ill who are homeless and living in shelters, substance abusers (MICA), and forensic patients. OMH's Shelter ICM Program operates out of OMH's New York City Regional Office (NYCRO), and has nine ICMs and a Coordinator, serving 100 clients.

During March 1994, while living at the Volunteers of America's Charles Gay Men's Shelter on Wards Island, Mr. H. was evaluated by OMH's Shelter Assessment and Referral Program (SHARP) team, which works in the city shelters to assist shelter staff in identifying and evaluating those individuals in need of psychiatric treatment, including hospitalization. Mr. H. was referred for involuntary hospitalization and was admitted to MPC at that time. During June 1994, at a time when one new ICM had been assigned to the Shelter ICM Program, creating available openings for additional clients, the SHARP Team Coordinator noted that Mr. H. had been readmitted to MPC during May 1994, and he was accepted and assigned an ICM. (All Shelter ICM Program clients are referred by the SHARP Team).

Mr. H.'s ICM was hired as the new staff member in the Shelter ICM program in May 1994. He was an experienced ICM with a Master's degree in Human Services who had worked as an ICM for Visiting Nurse Services for three years before joining the OMH program, and at the Ward's Island Shelter for four years previously. Prior to Mr. H.'s elopement, eight of the ICM's 11 clients were in the hospital, while the other three were in prison, a shelter, and housed in the community. The ICM noted that soon after Mr. H was first assigned to him, the patient was transferred to an open ward and was not viewed as presenting a particular danger to others. He was aware that Mr. H. had a substance abuse history and had gone LWOC several times during the present hospitalization. He had returned Mr. H to MPC following the patient's LWOC of July 20, 1994, as noted above. The ICM record states that, after each incident of LWOC, the ICM spoke with MPC staff about the need to notify him. However, the ICM apparently never alerted the ICM Coordinator so that she could work with the administration of MPC to ensure that ICMs were immediately advised of elopements and provided copies of the incident reports after *all* significant events.

The ICM seemed unaware of Mr. H.'s prior criminal history, his CPL admissions, or his previous history of assaults, although he had received this information. His assessment appeared to be based primarily on how Mr. H. presented during his hospitalization, with little awareness of how he was "on the outside."

The ICM informed CQC that he had visited Mr. H. weekly at MPC and had last seen him on December 22, 1994, when he had met with the patient and the treatment team. At that time Mr. H. had reportedly shown marked improvement, had been on Level III grounds privileges for about a month without incident, and the possibility of discharge to a MICA residence was discussed. Although MPC staff felt Mr. H. had demonstrated insight into his problems, the ICM believed that the patient's insistence on living alone after discharge raised questions about his insight and readiness for discharge.

In conversation and in his records, the ICM seemed unaware of Mr. H.'s prior criminal history, his CPL admissions, or his previous history of assaults, although he had received the Core History prepared at MPC for the current admission which made reference to these items. His assessment of the patient appeared to be based primarily on how the patient presented during his hospitalization, with little awareness of how Mr. H. was "on the outside." In failing to adequately assess Mr. H., the ICM did not identify signals from the material available in the patient's current record (assessments, Core History, DMHIS, etc.) to alert him to the need to explore the patient's history further. For example, although the form detailing Mr. H.'s movement history within OMH (the DMHIS), which was in the ICM record, noted that he had two admissions under Criminal Procedure Law (CPL) at MPC and at Mid-Hudson PC, a secure facility, as well as "outpatient" treatment at Central New York PC (indicating that Mr. H. was in a state prison at the time, receiving

mental health services), the ICM, like the MPC treatment team, made no further inquiries regarding this information and took no measures to review the old MPC records or acquire summaries of Mr. H.'s treatment at these other programs.

The initial assessment materials in the ICM record included an Expanded Brief Psychiatric Rating Scale (EBPRS) and a Level of Functioning Assessment (LFA) that are both due within 15 days of the first contact by the ICM. Information for these documents is to be based on meetings with the client, providers of service, significant others, and review of available records. The ICM completed these assessments early, however, 34 of the 47 items (72%) on the EBPRs were marked "Don't Know," including separate questions about whether the patient had physically assaulted anyone or set a fire "more than six months ago," both of which are part of Mr. H.'s history. In addition, 22 of the 52 items (42%) on the LFA were marked "Insufficient Evidence," and the ICM noted on the rating scale that he knew Mr. H.'s skills and behavior "not very well at all." The LFA requires that if more than 20 per cent, or 15 items, are marked "Insufficient Evidence," the assessment should receive special review and validation by the ICM Coordinator/Supervisor, who is to detail the reasons for the "Insufficient Evidence" ratings. Mr. H.'s LFA was not signed, and there was no evidence that it was reviewed by the ICM Coordinator/Supervisor, as there were no explanations for the "Insufficient Evidence" designations.

The Treatment Plan prepared by the ICM one month after his first contact with Mr. H. referenced the patient's drug and alcohol abuse, uncooperativeness, and personal hygiene needs as Mr. H.'s major problems. The plan did not address his propensity to go LWOC, although it was a major obstacle to his making a successful transition to a supervised setting, especially since his March admission had ended after his elopement, and he had already gone LWOC during his present stay.

On December 28, 1994, after learning of Mr. H.'s LWOC of December 24 while attempting to visit him on the ward, the ICM accessed the shelter data base (SCIMS) system, and also called Health and Hospitals Corporation to see whether Mr. H had been admitted to one of the NYC municipal hospitals. He also called the NYC Police Department to see whether Mr. H. had been arrested. The ICM also attempted to call the family and left a message at the number listed. The ICM informed CQC that a search in the community wasn't indicated as he had only known Mr. H. in the hospital and was unaware of particular places that he frequented.

There appears to be no formal requirement that ICMs physically search for their clients, and the decision to do so is said to be individualized, based on what is known about the client. However, discussions with the Director of the OMH ICM Program and the ICM Shelter Program Coordinator revealed that Mr. H.'s ICM, while taking some appropriate actions to try to locate the patient, should have done more. Specifically, he should have maintained daily contact with the agencies he had called on the first day, visited the family's home and sent a mailgram, and visited and called the Pastor at McCauley's Mission (whose name and number were listed on the ICM face sheet as an Emergency Contact). In addition, he should have contacted other private shelters, hospitals, and soup kitchens. To accomplish this kind of diligent search, the ICM also should have made better use of the other nine Shelter ICMs to assist in looking for Mr. H. in the course of their daily visits in the community. It still remains unclear where Mr. H. stayed after his LWOC prior to his arrest on January 4, 1995, as he was not registered at any of the city shelters, although it is known that he visited his family on Christmas day, who reportedly gave him $10 to return to MPC.

Prior Elopement Cases

During the last two years, CQC has reviewed three cases involving LWOCs by patients at MPC. The following are brief summaries of the findings of those reviews, the corrective actions promised, and the extent to which those actions have been implemented.

- D.C., a patient with Schizophrenia, Mild Mental Retardation, and Borderline Personality Disorder admitted to MPC under CPL status and converted to Voluntary legal status, was granted unescorted grounds rights from which he often eloped and subsequently proved unable to care for himself. He often abused alcohol off-grounds, was unable to care for his physical health, and was unable to protect himself.

  On December 5, 1992, D.C. was hit by a car the day after he eloped from MPC and sustained multiple fractures to his right leg and above the knee amputation of the left leg. In their plan of correction to CQC of November 10, 1993, MPC submitted a revised policy for Grounds Rights, as discussed earlier, and Supervising Psychiatrists agreed to "maintain a heightened vigilance in seeing to it that appropriate ground rights are in place for the patients." Based on a discussion with MPC's current Director of Quality Assurance, the proposed Q.A. mechanism to track numbers of LWOCs by treating psychiatrists and alert the supervisors to review the privilege granting practices of the physician was not put in place following the death of the former Clinical Director at MPC who was leading this effort.

- Patient C.A. was granted unescorted privileges, although she was noted to be highly delusional and paranoid, at high risk for elopement, and had failed to meet the criteria for unescorted privileges. Ms. A eloped on November 5, 1992 and was not returned to the facility until January 8, 1993. The facility's response of September 1993 to the Commission indicated that its policies for granting of privileges were under review and were subsequently revised during October 1993.

- During February 1993, J.R. eloped from the MICA unit while being escorted to the snack bar, and was arrested two months later for stabbing a toddler in the head with a pen near the shelter where he was living. Although Mr. R. had not clinically improved following his transfer on a 2 PC to MPC from Metropolitan Hospital after kicking a seven year old girl in the genital area, and had not progressed beyond Level I (limited escorted privileges), he was determined to not be a danger to himself or others when he eloped, and he was discharged from LWOC.

  Because J.R. had been converted to a Voluntary legal status and was determined not to be suicidal or homicidal, the police were not alerted that a potentially dangerous patient had eloped from the hospital, and the shelter which had informed MPC that he was there was not directed to return him to the hospital. Newspaper accounts revealed that prior to his hospitalization Mr. R had been in prison for burglary and there had been a warrant out for his arrest on assault charges since September 1992.

  In response, MPC began to classify all elopements from escorted privileges as Escapes and agreed to pursue the issue of obtaining "rap sheets" and information on outstanding warrants on other than CPL patients, for whom this information is available. As noted earlier in this report, during the current investigation the Commission was informed that approximately one year ago this issue was directed to OMH Counsel's Office and has currently been revived and is being addressed.

MPC Corrective Actions

The Director for Quality Assurance outlined for CQC investigators measures already implemented, those in process, and those being considered to address the issues raised by this tragedy. A Grounds Rights review process, which was in draft and under review at the time of RH's arrest, was implemented effective January 5, 1995, the day after his arrest. Specifically, an assessment form which compels answers and rationales from the treating psychiatrist is being completed for all patients currently on grounds rights and for all those who will be considered for grounds rights in the future. The form asks whether the patient has *any history* of dangerous behavior, including homicide or attempt, or suicide attempt, or other actively dangerous behavior like assault, rape, self-injury, property destruction or fire setting. It also addresses cognitive and functional deficits and asks if the patient has a history of LWOC or escape, taking illicit drugs, or making unsafe decisions regarding sexual activity. If any question is answered "Yes" or "Uncertain" and the psychiatrist is planning to order ground rights, an explanation/rationale is required in writing for each item. While the review process does not remove the ultimate decision from the psychiatrist, it does ensure that, if properly completed, the physician has considered these factors and if he/she has overridden the imposition of restrictions that might naturally flow from a positive answer to any one of these questions, the decision is supported by an explicit rational. At the present time, all assessments are reviewed by the Supervising Psychiatrist. In the future, the Privilege Assessment Review Committee (PARC), under the direction of the Clinical Director will review all forms of those patients with histories of criminal dangerousness.

In retrospect it is clear that if this procedure had been in effect prior to this incident, Mr. H would have had a more difficult time achieving grounds rights status, as he had a history of violent behavior, illicit drug use, fire-setting and multiple prior elopements.

The new grounds rights assessment form asks whether the patient has *any history* of dangerous behavior, including homicide or attempt, or suicide attempt, or other actively dangerous behavior.

On January 9, 1995 the Executive Medical Committee (EMC) of MPC met with experts well-published in the field of violence, including Jan Volavka, M.D.; Antonio Convit, M.D.; and Martha Crowner, M.D. and discussed assessments of dangerousness for patients. The EMC established a Risk Assessment Subcommittee which will develop a dangerousness assessment tool and will continue to evaluate policies and procedures for the granting of grounds rights. MPC is also revising the policy for notifications after elopements to include ICM workers, while also requiring that staff note who is contacted and that specific efforts to reach people are also documented in the record.

According to the Director of Quality Assurance at MPC, Chiefs of Service are now responsible for sending ward staff, accompanied by MPC Safety Officers, to search for all patients who Escape or go LWOC. If the patient is on Voluntary legal status it will be his/her decision whether or not to return to the facility. Additional personnel have been assigned to the Discharge Tracking Team to "maintain follow-up efforts to locate missing patients who have not returned to the facility, despite the efforts of the treating team." The facility is also taking corrective measures to ensure that essential prior information is secured. For example, the Unit Chief in charge of Admissions has been instructed to secure the medical records of patients from OMH facilities who present with a history of dangerous and/or criminal behavior or have a history of LWOC/Escape. Admission information will be reviewed to ensure it includes dangerous and assaultive behaviors. To facilitate this, sending facilities will be

Plans are being made to change perimeter security and to build a second secure recreation area.

notified that this information must be included when sending clinical records.

In addition, the short-term security measures on the grounds are being examined. The Dunlop Building will be closed as a point from which to enter and leave MPC; all people will have to pass through a manned security post in the Meyer Building. A security system involving a turnstile and an electronic card reading system is also to be installed at this security point. Patients will need to wear picture identification cards to be visible when moving about the facility. Also, plans are being made to change the perimeter security, including moving the manned security post and bus stop to more effectively check the credentials of individuals entering or leaving the grounds. A second secure recreation area is also being built which will allow patients to enjoy the outdoors while minimizing the risk of escape. OMH has also put together a long-term plan for MPC which includes capital construction for additional security measures.

Treatment and Discharge Issues

R.H.'s Comprehensive Treatment Plan of June 2, 1994 pointedly states the problems presented by R.H. and patients like him. "The patient has demonstrated to us a pattern of dealing with his illness. He quickly pressures the staff for an honor card and goes LWOC. He returns to live at the shelter, starts drugs/stops meds. . .and has recurring episodes of illness which result in the need for hospitalization. Is there something we can do to stop this cycle?" That, indeed, is the question.

After OMH has looked at security issues at its facilities, has reviewed procedures for the granting of privileges to patients, has improved its search and notification procedures, it must confront the question posed by R.H.'s treatment team: How do we stop the cycle? How do we help patients who often do not want help continue with the treatment that helped them regain control over their illness while in the hospital? How do we discourage their use of illicit drugs which, past history shows, led to their deterioration and rehospitalization or incarceration?

Twenty years ago, the New York State legislature enacted Mental Hygiene Law §29.15 which provides for the conditional release of an inpatient to the community. Similar authority has been in the law dating back to 1919. The conditional release statute invests the director of an OMH facility with the right to grant an individual a conditional release rather than an outright discharge when the staff familiar with the individual's case history believe the patient no longer requires active inpatient care and treatment but still has clinical needs which warrant a restrictive placement.

Each person on conditional release must be provided a written service plan which addresses supervision, medication, aftercare services, employment, and residential placement. The law allows the director of the facility to terminate the conditional release and order the return of an involuntary patient to the facility if the director judges the patient to be in need of inpatient care and treatment.

Each person on conditional release must be provided a written service plan which addresses supervision, medication, aftercare services, employment, and residential placement.

Safeguards have been included in the law to protect the civil liberties of patients. The law limits the duration of a conditional release for voluntary patients to 12 months (the patient may agree to an extension) and for involuntary to the remainder of the patient's authorized retention period. Notifications to Mental Hygiene Legal Services (MHLS) are required whenever conditional release is used. If the release is revoked, the law provides involuntary patients, their relatives and friends, and MHLS the right to request a hearing within 30 days. Voluntary patients on conditional release may not be returned to the facility against their will. They may, however, be readmitted if they meet involuntary admission criteria.

The conditional release statute recognizes a patient's right to leave the psychiatric center once he or she is no longer in need of care and treatment. It also recognizes that the medication and structure provided by the facility shapes a patient's behavior and without these aids some patients have demonstrated an inability to live in the community without placing themselves and others at substantial risk. Conditional release is a tool for keeping some structures in place for the patient and, one hopes, maximizing the patient's chances to stay safely in the community as much as possible and spend less time confined as an inpatient. This possibility is enhanced substantially when conditional release is coupled with Intensive Case Management services.

While the conditional release will provide structure for the patient and the reminder that society has a stake in his/her success, the ICM's monitoring and support, his/her personal interest in the success of the patient in the community and advocacy for

needed services can be the reminder that the patient is not alone in the struggle.

The Commission views this provision of law as a potentially useful tool which should be considered by OMH for patients:

(1) who have a history and current diagnosis of serious mental illness;
(2) who have engaged in repeated incidents of serious violent behavior;
(3) who have a concurrent diagnosis of alcohol and/or substance abuse; and
(4) who have previously been discharged from a psychiatric hospital, have failed to comply with their treatment plan, resumed their alcohol or substance abuse, and engaged in behavior which endangered themselves or others and led to their involuntary rehospitalization.

In contrast with the frequent poor discharge planning practices of psychiatric hospitals, documented in previous Commission studies, the Commission views this law as reinforcing the legal obligation of a psychiatric hospital, with respect to the group of patients described above, to:

- engage in meaningful discharge planning with the patient, a representative selected by the patient and involved family members in developing a discharge plan that is responsive to the needs of the patient and in which the patient has had an active voice (MHL §29.15). Previous Commission studies have indicated that such discharge planning rarely occurs and that, consequently, patients have little investment in following their recommendations;
- provide assistance to the patient through assignment of an intensive case manager to assure that the services and supports planned for are in fact available and accessible in the community;
- closely monitor the implementation of the discharge plan and the well-being of the patient and to make changes in the plans and services to accommodate changing circumstances; and,
- intervene on a timely basis should the patient's psychiatric condition deteriorate due to noncompliance with the plan, abuse of alcohol or drugs, or other reasons. This intervention can include seeking to have the patient rehospitalized if his clinical condition requires inpatient care and treatment.

The needs of patients for effective treatment and discharge planning and the right of the community to expect that patients with a history of violence will be confined until they no longer need inpatient treatment present substantial challenges to the OMH, and have prompted OMH to take action.

The pattern of treatment, elopement and decompensation often leading to behavior that is dangerous to self or others evidenced by R.H. is not uncommon in young male patients with few supports, many of whom also have substance abuse problems. The needs of these patients for effective treatment and discharge planning and the right of the community to expect that patients with a history of violence will be confined until they no longer need inpatient treatment present substantial challenges to the OMH.

Conclusions and Recommendations

Corrective actions by the Office of Mental Health will require physicians to consider past behavior in the community as well as current mental status and behavior during the last several weeks when considering privilege level and elopement status. Corrective actions improving security and strengthening search procedures have been implemented. Additional measures to ensure that clinicians secure relevant clinical records, especially those from CPL and secure inpatient stays are being instituted. These and other corrective measures are all designed to keep patients who require inpatient treatment at the facility and undertake aggressive measures when patients elope. The Commission believes these measures are appropriate and offers the following additional recommendations:

Access to Information

- OMH should reexamine its policies and practices regarding the care and treatment of *all* patients with past histories of violent behavior and behavior which seriously endangers the patient. Such policies should ensure, without regard to their *current* legal status, that facilities have reliable and accurate information of such past behavior to be able to develop appropriate treatment plans and to make decisions regarding the conditions under which they can be granted liberty without undue risk of harm to themselves or others. At a minimum, records from all secure hospitalizations and the records of all CPL admissions should be obtained.
- OMH should consider expanding the scope of the DMHIS to include information about hospitalization in non-state facilities. Such admissions now account for most of the admissions in the mental health system and their inclusion would make the DMHIS a much more useful tool in providing information about relevant past history to assist in clinical decision-making. The DMHIS should also note if a patient is discharged from LWOC or Escape status. Such information would be helpful to clinical staff in future admissions.
- Information about the significance of being an outpatient of Central New York Psychiatric Center needs to be widely disseminated in the mental health system, as it would alert staff to a history of criminal, and possibly violent behavior by the patient.
- Coordinators of the ICM programs need to ensure that ICMs are included as members of the treatment team and are advised of all significant events, including the granting of grounds privileges and leaves. Performance expectations for ICMs should be clarified and disseminated.

Clinical Evaluation and Judgment

- The Commission reiterates the recommendation it made to OMH in 1987[8] that patients who have left the facility without consent should not be automatically discharged after the passage of a specific period of time, as is the current policy and practice. Rather, there should be an individualized clinical review of each case to determine appropriate follow-up actions to assure the well-being of the patient and the safety of the community.
- In making decisions about grounds rights and other leave privileges, facility staff should examine not only a risk of suicide and homicide, but more broadly examine the risk of danger to the patient and others, especially in light of known history of the patient during previous admissions. They should specifically review information about past hospitalizations in determining what safeguards, if any, are needed.

[8] Investigation into Conditions at Creedmoor Psychiatric Center, March 1987, p. 22.

- Given the developing research findings about the association between mental illness, past histories of violence and substance abuse, OMH and MPC should reexamine policies and practices regarding the granting of grounds rights for patients with such histories. Specifically, OMH should consider the value of utilizing the conditional discharge provisions of MHL §29.15 to provide options for the supervision of such patients in the community.

Appendix A

A 20-Year History of Movement Through the Mental Health and Criminal Justice Systems

1970s

1971	1973	April 74	June 75	1975	Oct 75	Oct 75	Oct 76	Oct 76-Feb 77
Brookdale Hospital Depression	Brookdale Hospital Depression	Arrested/Charged Assault	Arrested/Charged Grand Larceny	Brookdale Hospital Depression	Arrested/ Charged Arson	Kings County Hospital Schizophrenia	Kings County Hospital	Kingsboro PC Voluntary Status

1970s - 1980s

June 77	July-Aug 77	Sept 77-July 78	July 78	Aug 78-Jan 79	1979	Feb 80	Feb-Sept 80	Nov 80
Arrested/Charged Reckless Endangerment	Kings County Hospital	Kingsboro PC	Arrested/ Charged Grand Larceny	Dept of Corrections Rikers Island?	St. Luke's Hospital	Maim. Med. Ctr. Hebephrenic Dilapidation	Manhattan PC Schizophrenia	Arrested/Charged Criminal Possession of a Weapon

1980s

Feb 82	Sept 82-Apr 83	Apr-Nov 83	Oct 83	Nov 83-Feb 84	Feb 84	Mar-July 84	May 84	July 84
Arrested/Charged Criminal Trespass	Manhattan PC Schizophrenia	Genesis House	Arrested/Charged Theft of Service [Transit]	Arrested/Charged Assault	Manhattan PC CPL Status	Manhattan PC Outpatient Clinic	Arrested/Charged Criminal Mischief	Manhattan PC Voluntary After Assault in Subway

1980s

Jan 86	Jan 86	May-June 86	July 86	Sept, Oct, Nov 86	March 87	Sept 87	Apr 88	June-Aug 88
Assaulted a Woman While on Pass Arrested, Returned to MPC	Assaulted 2 Patients MPC Placed in seclusion	LWOC	Bench Warrant	LWOCs	Discharged	Altro Rehab Residence	Arrested Assault on Subway	Mid-Hudson PC CPL

1980s - 1990s

Dec 88-Feb 89	Feb-June 90	June-Dec 90	Dec 92	Feb 93	Apr 93	Dec 93	Jan 1994	Jan-Mar 1994	Mar-Apr 1994
Downstate Corr. Facility Enrolled as "Outpatient" of CNYPC	Transferred to Clinton Corr Facility Paroled	Bronx PC, then LWOC	Charles Gay Men's Shelter	Bellevue Shelter	Arrested/ Charged Criminal Possession of a Weapon	Bellevue Shelter	McCauley Rescue Mission	Charles Gay Men's Shelter	MPC Involuntary to Voluntary to LWOC to Discharge

1990s

May 1994	May 20-23	May 23-Aug	Aug 30	Sept	Nov-Dec 1994	Dec 24	Jan 4, 1995	Jan 5 - Present
McCauley Mission	Bellevue Hospital Psychotic	MPC Schizophrenia, Substance Abuse 2 LWOCs & Return	Escape	MPC Positive Toxicology	MPC	LWOC	Arrested/Charged 2nd Degree Murder	Custody of DOC

Movement History[9]

1971	Brookdale Hospital—Hospitalized for depression for several months, dates unknown.
1973	Brookdale Hospital—Hospitalized for depression for several months, dates unknown.
4/6/74	Arrested/Charged: Assault 2nd degree with intent to cause personal injury with a weapon, Class D felony; Intent to use a dangerous instrument, Class A misdemeanor.
5/9/74	Disposition: Dismissed.
6/22/75	Arrested/Charged: Grand larceny, article from person, 4th degree, Class E felony; Criminal possession of a controlled substance, 7th degree, Class A misdemeanor. No disposition noted.
1975	Brookdale Hospital—Hospitalized for depression for several months; dates unknown.
10/20/75	Arrested/Charged: Set fire in his family's home. Arson, 2nd degree, Class B felony.
10/27/75	Kings County Hospital Forensic Ward. Psychiatric evaluation conducted relative to his arrest for the crime of Arson. Diagnosis: Apparent Schizophrenia—Catatonic Type, Medicated. Conclusion: Fit to proceed.
12/12/75	Disposition: Pled guilty on Arson charges, Class A misdemeanor, 3 years probation.
10/22 - 10/26/76	Kings County Hospital.
10/26/76 - 2/23/77	Kingsboro PC; Voluntary status.

[9] Data for the Movement History was compiled from the following sources: Information regarding R.H.'s prior hospitalizations was obtained from Manhattan PC (MPC) records and from information gathered by the MPC investigator regarding his prior stays at other non-State facilities. Material from the Central New York PC satellite clinic was also shared with CQC. Bronx PC provided CQC with the admission and discharge summaries of his 1990 hospitalization, and we received a summary of his stay at Mid-Hudson PC from OMH NYC Regional Office (NYCRO). Information relative to R.H.'s criminal history from 1974 through 1983, including all charges and dispositions, was obtained during the review of R.H.'s MPC CPL admission of February 1984. R.H.'s subsequent criminal history (1986-present), and material from Clinton Correctional Facility was obtained from NYCRO, which received it from OMH Bureau of Forensic Services and Bronx PC, respectively.

6/21/77	Arrested/Charged: Reckless endangerment, 1st degree, Class D felony; Escape, 3rd degree, Class A misdemeanor; Resisting arrest, Class A misdemeanor; and Criminal trespass, 3rd degree, Class B misdemeanor.
7/23 - 8/26/77	Kings County Hospital.
8/26/77	Disposition: Pled guilty, Criminal trespass, 3rd degree, Class B misdemeanor. Sentenced to time served.
9/7/77 - 7/20/78	Kingsboro PC; 2PC.
7/27/78	Arrested/Charged: Grand Larceny 2nd degree, Class D felony; Possession stolen property, 1st degree, Class D felony; Unauthorized use of a vehicle, Class A misdemeanor.
8/11/78	Disposition: Pled guilty to petit larceny, Class A misdemeanor. Sentenced to 5 months.
8/14/78 - 1/79	Department of Corrections (DOC) - Rikers Island(?).
1979	St. Lukes Hospital, Department of Psychiatry, dates unknown.
2/4 - 2/11/80	Maimonides Medical Center. Emergency admission, brought in by police after breaking into a car in an agitated state. Diagnosis: Hebephrenic Dilapidation. Transferred to MPC.
2/11 - 9/10/80	Manhattan PC; 2 PC. Transferred from Maimonides. Diagnosis: Schizophrenia, Chronic Undifferentiated, in remission. Believed to have experienced "a brief psychotic episode most likely due to substance abuse of undetermined origin." Discharged to apartment he found.
11/14/80	Arrested/Charged: Criminal possession of a weapon with intent to use, Class A misdemeanor.
12/24/80	Bench warrant issued on above charges of 11/14/80.
2/24/82	Arrested/Charged: Criminal trespass, 2nd degree, Class A Misdemeanor.
2/25/82	Disposition: Pled guilty to criminal trespass 3rd degree, Class B misdemeanor. Sentenced to 15 days maximum. Returned on warrant of 11/14/80. Disposition: Pled guilty to criminal possession of a weapon with intent to use, Class A misdemeanor. Sentenced to 15 days maximum.
9/20/82 - 4/18/83	Manhattan PC; 2 PC. Diagnosis: I: Schizophrenia, Chronic Undifferentiated; II: Schizoid Personality Disorder. Noted to be psychotic but not dangerous. Had lived in shelter and was to return to McCauley's Mission.
4/18 - 11/20/83	Placed in Genesis House, OMH-operated residence, following discharge from MPC. Received outpatient treatment at Manhattan PC's Westside Clinic.
10/30/83	Arrested/Charged: Theft of services (Transit), Class A misdemeanor; resisting arrest, Class A misdemeanor; and disorderly conduct. Disposition:

	Pled guilty to theft of service, Class A misdemeanor. Sentenced to 5 days maximum.
11/20/83 - 2/1/84	Arrested/Charged: Struck a woman on the street on her head, causing a concussion requiring treatment. Assault with intent to cause physical injury, 3rd degree, Class A misdemeanor. DOC: Rikers Island. Disposition: Adjourned Contemplating Dismissal. Found not fit to proceed and transferred to MPC for treatment.
2/1/84	Manhattan PC; Transferred from Rikers Island Pursuant to a 730.4 CPL Status. Admitting Diagnosis: I: Schizophrenia Chronic, Paranoid Type; Mixed Substance Abuse. II: Antisocial Personality Disorder.
2/29/84	Manhattan PC Forensic Committee granted the patient's request for honor card privileges, conversion to Civil Voluntary Legal Status and initiation of discharge process and notifications of his impending release.
3/29/84	Discharged from Manhattan PC. Discharge Diagnosis: I: Schizophrenia Paranoid, Chronic with Acute Exacerbation; Substance Abuse. II: None.
3/30 - 7/6/84	Manhattan PC - Outpatient Clinic Program.
5/31/84	Arrested/Charged: Criminal mischief, 4th degree. Bench warrant issued.
7/6/84	Manhattan PC. Voluntary. Presented at Roosevelt Hospital after assaulting a woman in the subway on the head with an umbrella. Had been living at Booth House. During much of three year stay he attended Manhattan PC's Westside Clinic's Day Treatment Program. R.H. went LWOC several times during this hospitalization after which he generally returned in a day or so. Diagnosis: I: Schizophrenia, Chronic Paranoid, with Substance Abuse. II: Antisocial Personality Disorder
8/11/85	R.H. assaulted another patient reportedly in response to the other's sexual advances.
11/30 - 12/1/85	LWOC from day pass. Noted not to be homicidal or suicidal. Returned via ER.
12/13/85	Caught smoking marijuana. Grounds rights suspended until 12/20/85.
1/4/86	Assaulted a woman he did not know while in Manhattan on pass. Arrested and returned to MPC (no charges noted). Transferred to an Admissions Ward until 1/15/86 when he was returned to his prior ward as improved.
1/24/86	Assaulted two patients at Manhattan PC in lobby of building, kicking one in the face inflicting multiple injuries. Transferred to an Admissions Ward and placed in seclusion.
5/31/86 - 6/1/86	LWOC. Failed to return from pass on time. He said he lost his tokens. Returned on 6/1/86.

7/2/86	Bench warrant issued for charge of damage to property.
7/3/86	Pocket knife, 2 1/4" confiscated from R.H. Said he used it to clean his nails.
9/27 - 9/28/86	LWOC. Not noted to be "suicidal or homicidal." Did not return from pass. Returned the following day and said he lost his token.
10/17 - 10/18/86	LWOC. Returned at 12:15 a.m. from pass. Said it was raining and he took his time. Not noted to be suicidal or homicidal based on ward staff and "recent progress notes."
10/24 - 10/25/86	LWOC. Failed to return from ground rights. Noted as Voluntary patient who is not suicidal or homicidal.
11/14 - 11/15/86	LWOC. Failed to return from day pass. "Patient is not suicidal or homicidal."
3/12/87	Discharged. Followed at MPC's Day Treatment Program he was attending while an inpatient as efforts to secure him a residential placement continued. Discharge Diagnosis: I: Schizophrenia, Chronic Paranoid. II: None.
3/12 - 9/29/87	Manhattan PC's outpatient program.
9/29/87	Placed at Altro Rehabilitation Residence on Wards Island.
4/18/88	Arrested after slashing the face of a passenger on a subway train with a straight razor who asked him for some change. Initially fled onto the tracks. When apprehended was psychotic and said "Why should I run. He asked for change. I didn't have any so I just cut him. I didn't do anything wrong."
4/18 - 6/20/88	Indicted for Assault, 1st degree, Criminal possession of a weapon, 4th degree. In DOC custody until found not able to stand trial and transferred to Mid-Hudson PC.
6/20 - 8/8/88	Mid-Hudson PC on CPL 730.5. Treated and found competent to stand trial. Diagnosis: I: Unspecified Psychoactive Substance Delusional Disorder II: Personality Disorder Not Otherwise Specified (Antisocial Traits).
8/8/88	Returned to custody of DOC to stand trial.
12/19/88	Pled guilty to crime of Assault, 2nd degree and sentenced to 1-3 years.
12/28/88 - 2/17/89	Downstate Correctional Facility.
12/29/88 - 11/20/89	Noted on Department of Mental Hygiene Information System (DMHIS) printout to be enrolled as "outpatient" of Central NY PC during this period, indicating that R.H. received mental health services through an OMH satellite clinic within the prison.

2/17 - 6/20/90	Transferred to Clinton Correctional Facility and subsequently paroled. Scheduled for release on 5/31/90 but began acting bizarrely. Retained until 6/20/90 when he was transferred to Bronx PC on a civil commitment.
6/20 - 12/20/90	Bronx PC—Admitted from Clinton Correctional Facility on 2 Physician's Certificate. On admission he was assessed as posing "no particular danger for violent acting out" and was found to be suitable for a general admissions ward rather than Secure Care. He was converted to voluntary legal status on 7/23/90. He earned grounds rights and overnight passes for home leave, despite periodic LWOC's and positive drug tests. On 12/1/90 he failed to return from honor card privileges and he was placed on LWOC, was noted to not be a danger to himself or others, and was discharged on 12/20/90. Diagnosis: I: Schizophrenia, Disorganized Unspecified. II: Anti-personality Disorder
12/22 - 12/24/92	Charles Gay Men's Shelter on Wards Island, operated by the Volunteers of America.
2/26/93	Bellevue Shelter, 30th Street.
4/1/93	Arrested/Charged: Criminal possession of a weapon; Menacing 3rd degree; and disorderly conduct. A bench warrant was issued for his arrest that was reportedly still outstanding at the time of the incident of 1/4/95.
12/29/93	Bellevue Shelter.
1/3, 5, 6, 8, 10/94	McCauley Rescue Mission—The Mission in lower Manhattan runs a Spiritual Growth program, provides overnight housing by lottery for 96 beds, and runs a "soup kitchen." Mr. H. had been known to the Mission for many years. Although we are aware of his overnight stays in 1994, he may have been there more frequently for meals. McCauley Rescue Mission is not a DSS shelter.
1/12/94	Bellevue Shelter
1/13,15, 1994	McCauley Rescue Mission
1/22 - 3/8/94	Spent approximately 30 nights at the Charles Gay Men's Shelter.
3/8/94	Referred to the OMH/ICM SHARP Team (Shelter Assessment and Referral Program) because R.H. was laughing inappropriately and having auditory hallucinations telling him to hurt people. Assessed and taken to Metropolitan Hospital.
3/8 - 3/9/94	Metropolitan Hospital - Screened and transferred to MPC for admission.
3/9/94	Manhattan PC - Admitted on Involuntary status to closed Admissions Ward. Acknowledged a long history of substance abuse including LSD, crack, alcohol and marijuana. Admitting Diagnosis: I: Schizophrenia, Chronic Disorganized II: Cocaine and Alcohol Abuse.

	Team was aware of his history of violence (including 1984 assault on a woman) and of his history of incarcerations. Although his Mid-Hudson stay was noted, no information regarding this stay was gathered and the team was unaware that the hospitalization was a CPL admission after he had slashed a man's face on the subway and was initially found unfit to proceed to trial.
4/6/94	Converted to Voluntary status. Granted honor card for unescorted grounds privileges; Enrolled in off-ward Central Rehabilitation program, including a Substance Abuse Program; Enrolled in drug research protocol and to be transferred to research ward.
4/8/94	LWOC - Attended Rehab for first time and did not return.
4/11/94	R.H.'s ward social worker called the McCauley Mission and was told by the Pastor that he had seen the patient (although he wasn't sleeping there) and seemed agitated. Pastor agreed to speak with him about returning to Manhattan PC.
4/15/94	R.H. was officially discharged from LWOC, and was noted not to be a danger to himself or others. Discharge Summary written on April 26 by ward psychiatrist notes "whereabouts unknown."
5/8, 10, 17, 18/94	McCauley Mission—On the 18th R.H. was referred to be seen by "Care for the Homeless" on Friday May 20. Care for the Homeless is a non-mental health "clinic" operated by the Institute for Urban Family Health which works out of the McCauley Mission on Fridays and a social worker visits on Wednesdays.
5/20/94	Care for the Homeless (CFH) evaluated R.H. and noted that he appeared to be psychotic and suffering from mental illness but did not appear to be dangerous. He was taken to Bellevue Hospital for evaluation.
5/20 - 5/23/94	Bellevue Hospital. R.H. was noted to be "requesting readmission to MPC," was floridly psychotic, yelling and gesticulating and was transferred to MPC.
5/23/94	Manhattan Psychiatric Center. Admitted on Voluntary legal status to closed unit. Diagnosis: I: Schizophrenia, Chronic Disorganized. Cocaine and Alcohol Abuse. II: None.
6/1/94	Psychosocial evaluation notes R.H. to be an LWOC risk.
6/2/94	Escorted grounds rights granted.
6/20/94	Assigned an ICM worker from OMH NYC Regional Office's Shelter ICM team.
6/21/94	Unescorted grounds rights granted to attend Central Rehabilitation programming including Substance Abuse Program.

7/5/94	Transferred to Community Prep Unit, Ward 3B, an Open Ward where all of the patients have unescorted grounds rights.
7/15 - 7/16/94	LWOC. Failed to return to ward, family notified by telegram. Returned on his own the following day. Remained on an open unit with full grounds privileges. His LWOC and return are not addressed in the record prior to his next elopement.
7/20/94	Urine toxicology taken on 7/12, examined on 7/18, informed on this date that it is High Positive for Marijuana.
7/20 - 7/26/94	LWOC—R.H. returned to ward on 7/26 when he was seen coincidentally by his ICM while ICM was on his way to visit the patient. The ICM brought R.H. back to MPC and he was transferred to a closed ward.
7/21/94	Urine toxicology taken on 7/19 and examined on 7/21 is High Positive for Marijuana.
8/17/94	Transferred to unit for individuals who are mentally ill and are chemical abusers (MICA). Placed on Level I, no off-ward privileges, except for fresh air breaks with staff escort.
8/30 - 9/1/94	Escape—Ran away from staff and patients while on fresh air break. Returned on his own two days later. Although noted as not homicidal or suicidal, R.H.'s elopement was designated as an "escape" consistent with facility policy that anyone who eloped while on escorted privileges was to be designated as an escape. R.H.'s family was notified by telegram, but his ICM was not notified. No one contacted McCauley Mission, although it was noted as a "Significant Contact" on R.H.'s face sheet.
8/31/94	McCauley Mission overnight.
9/4/94	Positive toxicology for Marijuana—collected on 9/4, examined on 9/15.
11/23/94	Unescorted grounds privileges, Level III is granted, upon formal written request and vote by MICA ward community, and MD's order.
12/22/94	Team Meeting. ICM met with team and R.H. Progress notes indicate patient has improved and showed insight into his illness and drug use.
12/24/94	LWOC. R.H. failed to return to the ward by 10 p.m. from 6 p.m. fresh air break. Psychiatrist on call was notified and completed incident report and noted that he was "Not considered dangerous." Telegram was sent to R.H.'s mother, as phone number listed had proven to be inaccurate some time ago. (Note: Telegram was later learned to have been lost in transit and was subsequently resent after R.H.'s arrest.) ICM was not notified.
12/28/94	ICM visited the ward and learned that R.H. went LWOC on 12/24/94. ICM checked to see if R.H. was at any of the Municipal (DSS) Shelters through the SCIMS (Shelter Communication Information Management System) system and HHC via an office that reportedly provides information

	on patients in all of their hospitals. He also checked to see if R.H. had been arrested. The ICM did not visit or send a mailgram to the family's address or check with his initial contacts on a daily basis. McCauley's Mission, as well as other private shelters, soup kitchens and hospitals were not called or visited.
1/4/95	Arrested and charged with 2nd degree Murder for allegedly pushing a woman onto the subway tracks to her death.
1/5/95	Discharged from MPC from LWOC following news of his arrest.
1/5/95 - Present	Custody of DOC. Evaluated at Bellevue Hospital Center Forensic Ward, and reportedly found fit to proceed to trial.

Appendix B

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

March 27, 1995

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

Dear Mr. Sundram:

I have reviewed the report of the Commission on the care and treatment of [redacted], dated February 28, 1995 and wish to respond to the findings and recommendations contained in the report. As you know, the safety and security of patients at Manhattan Psychiatric Center and all our state facilities is of the highest priority for the Office of Mental Health. The recognition the Commission's report extends to the numerous corrective actions that have already been initiated is appreciated.

The Commission's Report also challenges the OMH to look at the larger question posed initially by RH's treatment team: "...Is there something we can do to stop this cycle?" Indeed the cycle of elopement or discharge followed by drug use, non-participation in any treatment regimen, decompensation, commitment of a violent or anti-social act, arrest or re-hospitalization is characteristic of a few individuals with serious mental illness served by state and local providers. This is an issue with social policy implications that has increasingly thwarted our caregivers and deserves our most serious consideration.

In order to assure that clinical staff are up-to-date in this area, the OMH will engage its research affiliates to work with us in designing a "Technology Transfer" to our practicing clinicians. This effort will widely disseminate the latest findings and most effective interventions for the active treatment of individuals with this clinical profile. The design will include a six month series of case consultations, visits to inpatient units, and grand rounds to instruct and confer with specialists in behavioral and other relevant treatments. It is our view that there is a need to increase the base of clinical knowledge and expertise in serving these individuals at the same time that we increase security measures at our facilities.

Although your report accurately identifies a number of issues, the OMH had already undertaken a wide range of policy changes and corrective actions in response to problems highlighted by the [redacted] case. These include new policies regarding the definition and subsequent handling of missing patient cases, enhancements to the DMHIS information system, improved access to criminal history records, changes in the way grounds privileges are granted, and cooperation with other providers of mental health services to facilitate the sharing of information on previous inpatient stays, among others. Many of these actions address the recommendations included in your report. The attachment to this letter shows in detail how specific OMH actions address the concerns expressed as recommendations in your report.

Additional initiatives are anticipated in the next six months. We will continue to keep you apprised of our findings and progress and invite your periodic participation in improving this critical area of patient care.

Thank you for your thoughtful review of a sad and significant incident which will have repercussions for practice in the mental health system for many years to come.

Sincerely,

Joel

Joel Dvoskin, Ph.D.
Acting Commissioner

ATTACHMENT A:

The following is a point-by-point response to the recommendations made at the conclusion of the Commission's report on the care and treatment of [redacted]

1. - (A) Access to information - This recommendation stressed the need to access information on past incidents of violent behavior in developing current treatment plans and in making decisions about conditions regarding the liberty of persons with histories of dangerousness. It is now the policy at all adult facilities that information be routinely garnered from secure hospitals, such as Kirby Psychiatric Center and Central New York Psychiatric Center for all patients, including CPL patients. This was a mandated part of the action plans to prevent escapes prepared by each hospital following the [redacted] incident. OMH has issued a final policy directive (PC-310) effective March 15, 1995 which requires OMH facilities to use the Department of Mental Hygiene Information System (DMHIS) to identify pertinent clinical information for all persons admitted to OMH facilities. In addition, all patients must be asked about all prior hospitalizations and attempts must be made to procure relevant clinical information from any such hospital.

1. - (B) Expanding DMHIS - OMH is exploring, through its Information Services Office, the possibility of accessing information on non-state hospitalizations through DMHIS or other means. We expect to have initial recommendations by April 15, 1995. However, we have also initiated another means of cooperative planning with Article 28 hospitals providing psychiatric care and with local government.

OMH Counsel's Office has carefully reviewed the Confidentiality Law in New York State and has provided an opinion clarifying the ways in which confidential patient information can in fact be shared among parties involved in the care and treatment of patients. This legal opinion is forming the basis for planning meetings across the state aimed at facilitating the exchange of information across provider networks. The first meeting is scheduled in New York City on March 17, 1995, under the collaborative leadership of the New York City Regional Director of the Office of Mental Health and the New York City Commissioner of Mental Health. The commitment is to develop a protocol that will result in increased communication among City, State and voluntary providers on patients that are of mutual concern in terms of their status in the community.

1. - (C) The OMH has met with representatives of the Division of Criminal Justice Services (DCJS) to discuss OMH's access to criminal history records of patients. DCJS has indicated it will provide such information to OMH, subject to the promulgation of regulations and follow-up legislation. Therefore, OMH has developed draft regulations to clarify the authority of this agency to access criminal history records for all persons who are admitted to state psychiatric centers. These regulations will be promulgated within the next month and legislation will be introduced to clarify OMH's authority to access this information.

Further, OMH has developed a policy directive which describes procedures to be followed to: 1) access criminal history information, 2) assure that such information remains confidential to the extent required by State and Federal law, 3) guide facilities on steps to be taken to procure background information relative to a patient's criminal history and, 4) guide clinicians on the use of this information to make effective individualized risk assessments of patients regarding treatment privileges and discharge decisions. OMH is conducting training sessions for facility staff in early April and expects to implement facility access to criminal history in mid-April for all New York City adult hospitals, the three forensic hospitals, and three adult facilities with significant acute admissions (Capital District, Kings Park and Hutchings). The remaining adult hospitals will access criminal history information in the following 4-6 weeks.

1. - (D) Information from Central New York Psychiatric Center - A memorandum is being issued from our Bureau of Forensic Services to all state psychiatric centers, local government units and Article 28 hospitals informing them of the significance of an individual's status as an outpatient of Central New York Psychiatric Center. The OMH concurs that there is an incomplete understanding of this status across the mental health community.

1. - (E) OMH facilities have been instructed that clients' ICMs should be considered members of their treatment teams for their mutual clients. Therefore, ICMs should be informed of all meetings, be invited to participate, and be informed of all treatment outcomes. OMH facilities have also been asked to provided all treatment notes to ICMs and to be flexible in the scheduling of treatment meetings for patients with ICMs so that will be able to attend. ICMs are being required to attend treatment meetings for each of their clients no less than once per month.

2. - (A) Discharge from LWOC/Escape - OMH has issued a final policy directive effective March 10th regarding the treatment of missing patients. Missing patients will be placed into one of three categories: Absent Person, Escaped Person or Endangered Person. Under the new policy directive, escaped or endangered patients would remain on escaped person or endangered person status for a period of one year before being discharged. While on this status, hospitals will be required to take actions to attempt to locate and return the person and to notify others. Such patients will remain on this status for the period of one year, unless they have been returned to the facility or evaluated and determined not in need of commitment.

Also, legislation will be introduced to clarify the responsibilities of hospitals to notify law enforcement agencies of escaped patients, and the duty of police and law enforcement officials to take steps to attempt to locate and return dangerous patients to the hospital.

2. - (B) Use of known history in determining grounds privileges - OMH's current initiatives to improve dramatically the receipt and utilization of historical information are key to our "plans of action". A particular objective is the critical review of the intensity and frequency of clinical supervision available to clinicians making assessments about grounds privileges and discharge. Under the direction of each facility's clinical director, all discipline leaders are reviewing current practices for such supervision with the intent of refining standards for regular, available supervision and review of clinical documentation.

Two additional points are relevant here: (1) Each facility has put in place a three tiered review process for assigning clinical privileges, such as escorted or unescorted grounds privileges. The third tier is utilized for patients assessed to be currently at risk on the basis of past history and/or current behavior. This tier involves review by a special "Risk Management" or "Clinical Review" committee after review by supervising clinicians in the first two tiers, (2) each facility has developed a risk assessment form and protocol to use with patients designated at risk by dint of history or current clinical status. At the present time, a standardized protocol is under development through the leadership of clinical directors in the New York City Region. This product will be available by May 1995.

Finally, the Commission is recommending the use of the conditional release statute (Mental Hygiene Law, section 29.15) to improve discharges of a small cohort of high-risk individuals. As we stated in our recent meeting with Mr. Sundram and other CQC staff, OMH is evaluating the potential benefits of the use of this statute as a discharge tool versus the potential adverse impact on recipients' voluntary compliance with their discharge plans. OMH will be convening a workgroup to address the issue of improving successful discharges of currently high-risk patients. One avenue we will be exploring includes the use of intensive case managers, in concert with new hospital policies to require aggressive follow-up of certain high-risk patients.

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)**