

Psychiatric Emergency Room Overcrowding: A Case Study

NYS Commission on



**QUALITY
OF CARE**

for the Mentally Disabled

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Executive Summary

No recent case more poignantly and comprehensively illustrates the often tragic consequences of overcrowded public inpatient and psychiatric emergency rooms in the New York City public psychiatric system as does the story of Armando Peteros* who, after numerous encounters with the system over a three month period in 1987-88, allegedly stabbed and killed his elderly parents. This overcrowding, in combination with related problems such as staffing shortages on many units and in emergency rooms, incomplete and often unavailable patient records which led to inappropriate clinical decisions, and difficulties in establishing effective communications between police officers and hospital personnel, collectively contributed to a serious series of independent and seemingly unrelated decisions in the City's public psychiatric system which culminated in the death of Mr. and Mrs. Peteros, allegedly by their son Armando.

The persistent problems associated with the organization of psychiatric emergency rooms (PERs) and inpatient units in municipal hospitals in New York City as illustrated by this case have caused incalculable suffering for patients and their families and have frustrated and disheartened hospital staff members who attempt to deliver careful and considered psychiatric treatment. In an effort to deal with the demand for psychiatric inpatient beds, that far exceeds the supply, diversion procedures and "tripwire" agreements are implemented and result in the transfer of psychiatric patients from emergency rooms of New York City municipal hospitals to other

psychiatric facilities where there are vacant beds. Diversion procedures also allow patients, such as Armando Peteros, to be legally admitted to a hospital, held in the emergency room for up to 72 hours until a bed becomes available some place in the system, and then transferred to another facility.

Cramped emergency room accommodations, little or no psychiatric treatment beyond medication, inpatient admission delays as long as three days and the possibility of transfer to a facility inaccessible to family and friends typically face persons waiting for care and treatment in the PERs. Physicians and other hospital clinicians attempting to make assessments and provide treatment face inadequate space and insufficient privacy for interviews and assessments, difficulty in retrieving past hospital records, and inadequate social work staff to communicate with families, friends and providers to make discharge arrangements.

All of these factors and problems affected the care of Armando Peteros, seen four times in the Kings County Hospital PER from November 1987 through February 1988 for incidents of assaultive behavior and homicidal ideation.

The details of Mr. Peteros's visits to the Kings County Hospital psychiatric emergency room also illustrate the multiple effects of heavy and inappropriate dependence on PERs as the main source of psychiatric services in the City on evenings, nights, weekends and holidays. Essential services, including initial assessment, counseling, medication and referral for continual care occur under condi-

* A pseudonym.

tions that often border on chaos and are conducive to poor clinical judgement. These PERs also serve, by default, as "holding areas" where drug and alcohol detoxification begins, as refuges from domestic violence, and as shelters offering some warmth, safety and minimal social services. This is particularly true for Kings County Hospital, where Armando Peteros was frequently seen, because it serves as the assessment point for the mental health needs of approximately 1.8 million Brooklyn residents. Many of the 13,000 patients who annually present there with psychiatric symptoms are difficult to treat: 30-40 percent are substance dependent as well as mentally ill, many are homeless, and most are indigent.

Since the time of the tragedy visited on the Peteros family in 1988, the problems and deficiencies documented in this report have persisted in the municipal hospital system in New York City with little promise of immediate abatement. What has happened, and which leads to some hope for future improvements, has been the acknowledgement of State and City officials in response to the Commission's preliminary findings and recommendations in this case and to other Commission reports dealing with problems of psychiatric care in New York City, of the multiple serious systemic deficiencies which prevail and a public commitment to cooperative efforts to address these deficiencies.*

In an effort to assist in the amelioration of these conditions, the Commission has made a number of systemic recommendations to the State Office of Mental Health (OMH) and the City Health and Hospitals Corporation (HHC), more fully detailed on pp. 12-14 of the report, which include the following:

1. The phase-out of the "tripwire" and diversion procedures as soon as possible. In order to facilitate this goal,

the Commission recommends that OMH provide substantial technical assistance to HHC hospitals to ensure that patients who no longer require acute care are placed in more appropriate settings. At the same time, HHC facilities need to examine their own staffing needs to better comply with the requirements of sound clinical practice, as well as state laws, governing discharge planning.

2. Support of both the OMH plan to expand community residence beds over the next ten years to accommodate an additional 16,000 persons and the OMH intensive case management initiative. In addition, OMH should assure, on a regional basis, the capacity of outpatient programs to provide extended hour clinic services, crisis services both on site and through mobile units, family and in-home support and meaningful follow-up, including home visits to patients who fail to keep appointments and who are likely to decompensate.
3. The Department of Health, in consultation with OMH, should develop specific standards for psychiatric emergency rooms which include staffing standards. The requirement that each PER develop a consistently dependable system for in-house record retrieval also should be included in the operating standards.
4. Following an inpatient psychiatric stay, a summary of treatment should be sent to the provider of outpatient clinical services and the case manager. Similarly, when patients are treated in PERs and released, this information should be communicated to the outpatient service provider and case manager. Outpatient clinics must assume respon-

* *Admission and Discharge Practices of Psychiatric Hospitals*, April 1988.

sibility for taking reasonable measures to follow-up when patients fail to keep appointments.

5. OMH and the HHC should develop with the NYC Police Department a protocol to ensure that hospital personnel can secure specific detailed information from police officers about the circumstances under which a patient is brought to the PER. This might include a procedure whereby clinicians can get this information directly from the precinct.

As indicated above, this Commission report and its recommendations already have elicited positive responses from OMH and HHC, as well as from the State Health Department and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, all of which are appended. All parties agree that, while tripwire arrangements have been a necessary safety valve in relieving emergency room overcrowding, alternative measures must be found. To this end, OMH is preparing a position paper outlining alternatives to the existing system and possible assumption by OMH of more responsibility for the care of patients requiring longer lengths of stay, in exchange for a reduced role in providing acute psychiatric care in New York City. Negotiations between OMH and HHC around this issue have begun. In addition, OMH notes that it is in the process of reviewing outpatient programs to assess their adequacy in meeting the needs of the seriously and persistently mentally ill.* OMH also has reviewed the status of psychiatric emergency services in municipal State hospitals in New York City and has developed both short-term strategies to alleviate the overcrowding and a multi-year plan, including a comprehensive legislative proposal, to restructure emergency services. This proposal,

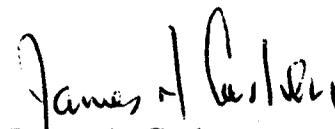
highlighted in the Governor's 1989 Message to the Legislature, would return PERs to their proper use. A second plan for the establishment of Supported Housing would provide rent subsidies to assure that persons with mental illness will have access to available housing.

Similarly, HHC has responded that among its initiatives is the establishment of a crisis clinic that extends operating hours and a mobile outreach capacity at Kings County Hospital, as well as a comprehensive managed care program for 100 "heavy system users" in South Brooklyn at Coney Island Hospital.

The Commission is pleased that the findings and recommendations of this report have been helpful in establishing a context in which the dialogue among OMH, HHC and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services can address the serious systemic deficiencies which were exemplified in the tragedy of the Peteros family. While resource restraints may limit immediate implementation of remedies, the Commission welcomes the current good will and cooperative efforts of these agencies.



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* The Commission is nearing completion of a legislatively-mandated study of outpatient mental health services with results to be published in the spring of 1989.

Acknowledgements

The preparation of this report would not have been possible without the cooperation of the clinicians and administrators who deal every day with the problem of psychiatric emergency room overcrowding in New York City. For their insight and candor, we are grateful.

The Commission also acknowledges staff efforts in the preparation of this report:

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Introduction

The personal story of one man or woman, whether fact or fiction, is often the vehicle that best helps us understand the tenor and events of a time. Surely Ayla in *The Earth's Children* trilogy made the Ice Age real, while Stephen Crane's Henry Fleming in *Red Badge of Courage* brought readers face to face with the realities of youth and war. Though not as grandly, but far more tragically for its reality, the story of Armando Peteros, as it was screamed in headlines in New York City newspapers in February 1988, spoke clearly of the state of the troubling conditions in public psychiatric facilities in New York City.

On February 26, 1988 at approximately 7:00 p.m., Armando Peteros was brought to Kings County Hospital Psychiatric Emergency Room by police after allegedly stabbing and killing his elderly parents. The next day he was admitted to Kings County Hospital Forensic Unit for evaluation and treatment following his arraignment. The story of this tragedy began to unfold three and one-half months earlier.

Background

Armando Peteros was born in 1950, the only child of Greek immigrant parents. He dropped out of college at age 23 in his senior year because "he wasn't thinking right." He returned one year later and graduated in 1975. Mr. Peteros's psychiatric history notes that in 1976 when he reported auditory hallucinations, his mother took him to a prayer meeting hoping for a cure. Shortly thereafter, the young Mr. Peteros moved in with the pastor and his wife and remained with them for several years.

In 1980, failing health prompted Armando Peteros's parents to ask him to return home and help care for them. When Mr. Peteros returned, he began punching himself in the face, crying and wailing about his desire to die. Following an evaluation at Flatlands Guidance Center and attendance at day treatment for a short time, he was seen at South Beach Psychiatric Center's Mapleton Clinic, where he remained a patient. In 1981, Mr. Peteros experienced his first inpatient psychiatric hospitalization, a 20-day stay at Downstate Medical Center, following which he was discharged to his parents with a diagnosis of schizophrenia, chronic paranoid type.

During the two year period 1981-1983, Mr. Peteros regularly attended his weekly sessions with a psychologist and a psychiatrist at the Mapleton Clinic. He was reportedly compliant with medication, but remained very depressed and, according to case notes, entangled in an intense symbiotic relationship with his mother. The family's extreme isolation and the ill health of both parents made it difficult for clinicians to determine whether Mr. Peteros's inability to function was due to a psychotic process, or was his way of coping with his parents' demand that he take care of them, a demand which he was rejecting.

The outlook for Mr. Peteros began to brighten in late 1985. Through early 1987, he held a full-time job as a file clerk and earned a promotion to supervisor. He was attending a church singles group and was getting along well with his parents, according to case notes. Mr. Peteros' complaints of drowsiness, coupled with the remission of his symptoms, encouraged his Mapleton Clinic psychiatrist to gradu-

ally reduce his medication, and to acquiesce in August to his patient's request and reduce his medications to a single daily 50 mg dosage of Thorazine. Mr. Peteros appeared to cope well with being laid-off his job and his father's heart attack in spring, 1987 and enrolled four nights a week in a word processing school. By October 30, 1987, Mr. Peteros was off of all medication. Twelve days later, he was taken to the Kings County Hospital Psychiatric Emergency Room, the first of a series of visits that culminated with the most tragic one, February 26, 1988, some three and a half months later.

November 11, 1987

Mr. Peteros's parents called the Mapleton clinic and reported that their son was delusional and had pushed his mother. Urged by a neighbor, the family then called the police. The Mapleton Clinic psychologist spoke to the police at the Peteros's home and informed them of Mr. Peteros's history. She subsequently updated the patient's Danger Profile to include "assaultive to mother (no injuries)" and noted that, in response to the police attempts to enter the family's apartment, Mr. Peteros "took kitchen knives to protect himself." This description, although accurate in some respects, was substantially different in tone from the Kings County Hospital records, which noted that Mr. Peteros was brought in at 4:20 p.m. following an assault on police with two butcher knives with the intent of stabbing them. Police responded using a stun gun.

At 6:30 a.m. the next morning, after receiving medical clearance, Mr. Peteros was admitted to Kings County Hospital Psychiatric Emergency Room. He was medicated, placed on 1:1 assaultive watch and confined to the holding area, because there were no inpatient psychiatric beds available. While the Kings County Hospital Psychiatric Emergency Room notes relate Mr. Peteros's violence toward the police, they make no men-

tion of the cause of the police call, namely, violence toward his parents. Although the psychiatric emergency room staff made attempts to contact Mr. Peteros's parents, they were not successful.

The scene in the Kings County Hospital Psychiatric Emergency Room on November 12, 1987 was typical of many municipal psychiatric emergency rooms. In the holding area with Mr. Peteros was a second patient, also on diversion status awaiting a bed.

Diversion procedures were instituted in Kings County Hospital to facilitate the movement of persons out of the over-crowded psychiatric emergency room, where staff were ill-equipped to handle the frequent crises associated with acutely mentally ill persons and were unable to give the studied, calming care necessary for stabilization. When the Director of Psychiatry or his designee determines that persons may no longer be safely admitted, because of overcrowding, to the Adult Inpatient Service, patients may be placed on diversion, allowing them to be transported to other hospitals where psychiatric beds are available or, if no beds in the system are empty, allowing the patients to be legally admitted and held in the emergency room until an appropriate disposition can be made. Depending on individual circumstances, this may be admission to the first available inpatient bed, or discharge if the patient appears no longer able to meet the legal threshold for involuntary admission. At Kings County Hospital, diversion procedures are generally activated when the inpatient psychiatric units census is over 160. On November 12, 1987 the census was 167. Similar arrangements, called "tripwire" agreements, also have been developed in an effort to cope with the surging demand for inpatient hospitalization. Under these agreements, patients are sent directly from psychiatric emergency rooms to State psychiatric centers once the acute facilities are at capacity.

Because of the diversion protocol, and despite his seven-year affiliation with South Beach Psychiatric Center's Mapleton Clinic, Mr. Peteros was transferred to Kingsboro Psychiatric Center on November 12. According to South Beach P.C., at that point Mr. Peteros was removed from the rolls of the Mapleton Clinic to avoid double-billing for his care.

November 12--December 2, 1987

Staff at Kingsboro Psychiatric Center recognized Mr. Peteros's longstanding association with the Mapleton Clinic and contacted staff there, shortly after he was admitted, who made clear their willingness to see him again upon discharge. Mr. Peteros's Kingsboro Psychiatric Center records indicate that, during his hospitalization, he made gradual improvement on a regimen of medication. Although counseling was supposed to be provided for 30 minutes three times a week, the absence of case notes suggests this was not done. During this admission, Mr. Peteros was accepted for case management services under the Community Support Services (CSS) Program. This program provides an array of services for adults with a history of serious mental illness. Persons who have had multiple or long-term admissions to a psychiatric hospital, or frequent contacts with crisis service, are among those eligible for CSS services. Case management services are designed to assist clients in obtaining resources needed to live safely and productively in the community. Typical services might include linking clients to financial, social, vocational, residential or medical resources while building the personal/professional relationship necessary to help clients maintain these connections.

Mr. Peteros's CSS case worker saw him once during his screening on November 19, 1987 while he was an inpatient at Kingsboro Psychiatric Center. The next attempted con-

tact with the patient was on December 30, 1987, when she called the ward and was informed that Mr. Peteros had been discharged.

A three-member board at Kingsboro Psychiatric Center responsible for reviewing the discharges of patients who have been determined seriously dangerous to themselves or others cleared Mr. Peteros for discharge on December 1, 1987. He left the hospital the following day with a two-week supply of medication and an appointment with Dr. A, his therapist at the Mapleton Clinic for December 7, 1987.

December 9--December 22, 1987

Dr. A reported that, following her first post-discharge meeting with Mr. Peteros on December 9 (he failed to attend the December 7 appointment), she felt the patient had been discharged prematurely but was not ill enough to require readmission. Mr. Peteros assured Dr. A that he would continue to take his medication and would see his outpatient psychiatrist, Dr. B, on December 11. Mr. Peteros missed this appointment and subsequent ones on December 14, 16 and 22. Clinic contact with the patient's mother revealed he "wasn't sleeping and was packing to leave."

December 26--December 28, 1987

On the day after Christmas at 4:20 p.m., the police again brought Mr. Peteros to the Psychiatric Emergency Room at Kings County Hospital for "violent behavior" toward his mother. It is unclear what this behavior actually was, because case record notes indicate that, in a telephone conversation between psychiatric emergency room personnel and Mrs. Peteros, the patient's mother, stressed that, although she had hit him with her cane, her son had not retaliated. Staff had not located his November 11 psychiatric emergency room record, so the treating physician had no knowledge of the previous violence associated with Mr. Peteros' illness. Mr.

Peteros was released early that same evening. He failed to keep a December 28 appointment with Dr. B.

February 13-15, Presidents' Weekend

On February 13, 1988 at 11:00 p.m., police brought Mr. Peteros to Maimonides Medical Center when, responding to a persistent delusion, the patient called the police reporting he had chopped up a woman. At Maimonides, he was medicated and transferred to Kings County Hospital on February 14 at 3:25 a.m. where he was evaluated by Dr. C, noted to be "apparently not violent" and discharged at 6:25 a.m. with no medication and a follow-up appointment at Kings County Hospital-Outpatient Department on February 18. When interviewed later, Dr. C reported that he called the patient's parents during the evaluation. They reportedly denied their son's previous violence and asked the physician to send him home. Dr. C also denied any knowledge of Mr. Peteros's treatment at Kings County Hospital on November 11, his attack on police, his recent hospitalization at Kingsboro Psychiatric Center or his involvement with the Mapleton Clinic.

Fifteen hours after first appearing at the Maimonides Medical Center, Mr. Peteros was again brought by police to Maimonides on February 14, 1988 at 4:00 p.m., after calling the police and again claiming to have chopped up a woman. The nurses' triage notes at the hospital confirmed that Mr. Peteros was convinced he had "hacked up" a popular singer and "put her pieces in New Jersey". The notes also stated that the patient had attacked police when they attempted to bring him to the hospital. During the middle of the night, Mr. Peteros was transferred to Kings County Hospital, and admitted at 3:45 a.m. on Monday of Presidents' Weekend (February 15) to the psychiatric emergency room holding area on diversion status as a voluntary patient. Again, Kings County Hospital staff failed to

secure a copy of his November 11 psychiatric emergency room record or his December 26 record.

After waiting in the Kings County Hospital Psychiatric Emergency Room on diversion status for approximately 12 hours, Mr. Peteros was re-evaluated by Dr. D, attending psychiatrist and Unit Chief from the Inpatient Service, who was working for the first time in the psychiatric emergency room evaluating the clinical status of patients on diversion. He found that Mr. Peteros was "not in need of acute psychiatric admission" and entered a different diagnosis: mixed personality disorder with hysterical features. At 3:30 p.m., he wrote an order to discharge Mr. Peteros.

Not documented in the record, but reported by the physicians later to the Commission investigator, following the order for discharge, Dr. C (who had seen the patient during his short psychiatric emergency room visit a day earlier) suggested to Dr. D that he call the patient's parents before releasing him. Reportedly, during the telephone conversation, the elderly Mr. Peteros told Dr. D that the patient couldn't come home. As a result, Dr. D informed Dr. C that he had reconsidered and asked him to cancel the discharge order. Dr. D then left the psychiatric emergency room.

Shortly thereafter, Mr. Peteros approached Dr. C and asked to be released. He pointed out that he was a voluntary patient, was getting no treatment and had been sitting in the psychiatric emergency room for fifteen hours. Compelled by the logic of this argument and Mr. Peteros' then calm demeanor, Dr. C called Mrs. Peteros, who requested that her son be kept for two days. On interview, because none of these contacts with the family were noted in the record, Dr. C admitted that this request upset him in light of his inability to guarantee even the availability of an inpatient bed in the next two days. In the end, Dr. C reported Mrs. Peteros "felt safe having her son come home." Dr. C merely crossed out the order he had

written to cancel the discharge and let Dr. D's discharge order stand. Mr. Peteros left the psychiatric emergency room, reminded that he had a February 18 Kings County Clinic appointment (which he later failed to keep).

Conditions in the Kings County Hospital Psychiatric Emergency Room over President's Weekend were even more stressful than on November 12, 1987. The psychiatric emergency room was very crowded; there were 12 patients on diversion, bringing the psychiatric service patient census to 174; the service was instituting a process for weekend evaluations

of patients on diversion status. These evaluations would determine whether there were reasons to rescind any admission decisions because of changes in patients' clinical status.

February 26, 1988

At 7:00 p.m., Mr. Peteros was brought to Kings County Hospital by police after allegedly stabbing his parents to death. According to the psychiatric emergency room records, he stated, "I'm crazy, damn it. I know I killed my parents. Nurse, are you going to keep me? Please don't let me go this time."

Discussion

The Impact of Overcrowding

“Wartime triage,” “basically inhumane” and “unfair to patients” are descriptions used by Kings County Hospital physicians to characterize the diversion system used by Kings County Hospital and other municipal hospitals during periods of severe overcrowding. While it will never be possible to identify exactly what effect the state of the psychiatric emergency room had on admission and discharge decisions each time Mr. Peteros required emergency psychiatric evaluation and possible treatment, it is clear from Commission interviews of staff involved that reasonable men and women making these decisions consider, in conjunction with the patients’ symptoms and history, the conditions to be endured while on diversion status. These include confinement in a small, often noisy space, sometimes with many other patients, some of whom may be agitated; no place to rest comfortably; no treatment beyond medication; and, no assurance as to when a bed will become available. This can continue for up to three days.

The Psychiatric Emergency Room at Kings County Hospital was on diversion status every single day from November 11, 1987 (Mr. Peteros’s first psychiatric emergency room admission) until February 26, 1988, when he was brought in after allegedly murdering his parents. During the Christmas holiday period ending on December 28, 1987 (Mr. Peteros was seen on 12/26) nine patients were on diversion and the inpatient unit census was 174. During Presidents’ Weekend, 12 patients were awaiting beds in inpatient settings.

The impact of overcrowding, common in all of the municipal and State-run inpatient

facilities in New York City, is felt particularly hard in the Kings County Hospital Psychiatric Emergency Room, because it serves as the assessment point for 2/3 of the population of Brooklyn, approximately 1.8 million people. Many of the patients who present with psychiatric symptoms are difficult to treat: 30-40 percent are substance dependent as well as mentally ill, many are homeless, and most are indigent. Approximately 13,000 patients a year pass through the small psychiatric emergency room, sitting on one of the 16 chairs, standing, or lying on one of the cots in the holding area and in the corridor near the freight elevators.

Just as it is difficult to determine what effect diversion status has on admission/discharge decisions, it is also difficult to assess how much of the disregard for standard procedures evidenced in Mr. Peteros’s treatment was due to the chaotic state of the psychiatric emergency room. Physicians failed to document important telephone contacts with the family, psychiatric emergency room personnel failed to secure vital records from previous visits, physicians failed to closely review material sent from Maimonides Hospital Emergency Room, physicians failed to personally complete vital records, and physicians and other clinical personnel failed to write a discharge plan. These failures, in effect, created multiple situations in which physicians made decisions based on Mr. Peteros’s presenting condition at the time (which during the January and February psychiatric emergency room visits was described as “anxious,” “no psychotic material noted,” and “minimal thought disorder”), without benefit of an accurate psychiatric history for events as recent as six

weeks earlier. The physicians interviewed consistently noted that, had they had prior treatment records and reliable consistent information from the family, they would likely have changed their admission/discharge decisions. Repeatedly, physicians denied knowledge of Mr. Peteros's increasing aggression, as evidenced by his attack on his mother and the police. In part, this case is especially dispiriting because it illustrates the system's failure to provide effectively for someone who was well known to the local providers of psychiatric services, i.e., he was repeatedly brought to the same psychiatric emergency room, he had had a recent inpatient stay, he had been assigned a CSS case manager, and he had maintained close contact with an outpatient clinic for seven years.

In crises, when physicians are pressed for time, other clinical and support services need to operate maximally. Certainly, this was not the case here. Why were records from recent psychiatric emergency room visits unavailable? Did someone look for them carefully, so that files of persons with last names spelled slightly differently were checked? Were aggressive recruitment and staff rescheduling efforts undertaken to fill the vacancies cited as the reason no hospital Social Services Department personnel were available to contact the family and explore Mr. Peteros's relationship with his parents and his incidents of violence, or to contact Kingsboro Psychiatric Center, the Mapleton Clinic or the police?

It is not the point here to imply that, had conditions been optimal, physicians could have predicted Mr. Peteros's violence. Indeed, his psychiatrist from the Mapleton Clinic, whom he had seen for seven years, was surprised at the course of Mr. Peteros's decompensation, expecting his aggression to be directed inwards, as when he first became ill.

Neither is it the point to absolve the failures of the physicians and other staff members

as inevitable given the enormity of the burden and their lack of resources. Critiquing his own failure to document his work, one physician used the word "terrible," an apt description of a number of documentation omissions by physicians in this case. Such omissions are more than just technical failures to comply with paperwork requirements. They effectively deprived all other clinicians, who made decisions about the care of this patient, of access to important and relevant information.

What is important is the recognition that the price of the relentless demands placed on the psychiatric emergency rooms by the lack of available inpatient beds or alternative emergency and crisis services, ultimately, is paid by the patients and their families. While the diversion system was an understandable response to the inpatient bed gridlock, its effect on the quality of care for patients admitted under its strictures can be devastating. As one physician reported, "You admit [patients] and three days later you still see them there (in the Emergency Room) yelling." Alternatively, patients are shuttled among hospitals in search of a vacant bed, transported in the middle of the night, hopelessly fragmenting the care they receive.

Underlying the staggering demands placed on the municipal hospital psychiatric emergency rooms is the reality that, by and large, the psychiatric emergency rooms are the main source of psychiatric services evenings, nights, weekends and holidays. These services include the traditional psychiatric services of assessment, counseling, medication prescription and referral for continued care. They also include serving by default as "holding areas" where drug and alcohol detoxification begins, as refuges from domestic violence, and as shelters offering warmth and minimal social services (few psychiatric emergency rooms will turn someone out without a pair of shoes or a coat.)

To the extent that inadequate shelter and the other faces of poverty pervade urban society, psychiatric emergency rooms, not unlike all other helping institutions, will be forced to address needs they were never intended to fill, and will do so wantonly. However, it is not inevitable that psychiatric emergency rooms should continue to fill the psychiatric needs of patients which, had they occurred during regular business hours, could have been handled by out-patient clinics. Extended clinic hours, including evenings, nights and weekends; expanded mobile crises services; meaningful outreach efforts (not limited to form letters) that include home visits and regular telephone contact; and short-stay crisis residences are some of the essential dimensions of comprehensive out-patient treatment and emergency services.

Similarly, the demands of the chemical abusing patient must be met in a different manner - one which allows for assessment of the patient and the establishment of a differential diagnosis (which distinguishes the mentally ill chemical abuser from the drug abusing patient whose bizarre behavior has no psychiatric features) in an environment more structured than the psychiatric emergency room. Such a system would likely reduce the number of drug abusing patients erroneously admitted to a psychiatric bed, while also reducing the congestion and chaos in the emergency rooms. Finally, City and State cooperation, aimed at returning responsibility for providing for patients who require long-term care to the State centers and entrusting acute care provision to the City and voluntary hospitals, ultimately will be necessary to reduce emergency room overcrowding and end the diversion system. Such a division of labor will be possible only after each system frees

beds presently inappropriately occupied.

As reported in the Commission's April 1988 publication, *Admission and Discharge Practices of Psychiatric Hospitals*, eleven percent of the patients occupying acute care beds could more effectively be served in less intensive treatment settings.* Of this 11 percent, 33 percent skilled nursing or health related level of care, eleven percent require substance abuse services and 26 percent were determined able to live in a community residence.

The scarcity of appropriate placements for patients ready for discharge is not confined to acute care settings. Of the approximately 17,000 long-term patients (defined as length of stays over 90 days) in State psychiatric centers, approximately one-third are appropriate for a community residence; family care or an adult home--all options considerably less restrictive for the resident and far less expensive. An additional one-third of the remaining patients are appropriate for services in nursing homes and health-related facilities.

Clearly, a major component of efforts to break the "house is full" situation in New York City's mental health system, must be an intensified effort to discharge patients to more appropriate settings with suitable outpatient services. Some of these placements could be made today; others require the development of additional supervised living programs, and low-income housing and day programs that respond to the patients needs for rehabilitation, vocational and education services, and treatment for alcohol and substance abuse problems.

Ironically, the fact that Mr. Peteros had a place to live and a family worked to his detriment and ultimately to theirs. In a system

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

as stressed as the Kings County Hospital Psychiatric Emergency Room, reliance on the family as the provider of first resort in cases where inpatient admission may be desirable, but not essential, becomes a *sine-qua-non*. This places an extraordinary burden on families and, as the events of this story indicate, may fail to identify those situations where the patient's pathology places the family in danger.

Communication With Police

Mr. Peteros was taken by police either directly to Kings County Hospital Psychiatric Emergency Room, or to Maimonides Emergency Room, on four occasions from mid-November, 1987 to mid-February, 1988. Yet, physicians claimed to be unaware he was dangerous. This situation baffles and angers both police and physicians. Frequently, police officers feel like front-line mental health workers: they are called by distraught family members or neighbors to meet the needs of disturbed patients when Crisis Services are lacking or overburdened.

Because ambulance service is a luxury not available to many of the patients who use Kings County Hospital-Psychiatric Emergency Room, police officers (who remain with the patient until a treatment decision has been made) are frequently the persons available to physicians who can give the most accurate and complete account of the events that occasioned their intervention. This information is essential to clinicians who are evaluating patients' potential dangerousness to self or others. Yet, clinicians often fail to talk to police officers or fail to thoughtfully question them to gain as complete a picture of events as possible.

Mr. Peteros is a case in point. On February 14, 1988, he was accompanied by a policeman in the psychiatric emergency room, but the officer was never questioned. When questioned why no such interview took place, the

physician recounted that, in his previous experience, police were seldom helpful. Usually, he noted, the officers had nothing to offer. "They just have an "AIDED-EDP" card indicating they are replacing an officer who has gone off duty." This references a second common obstacle to effective communication. Often the officer who escorted the patient goes off-duty and is replaced by another officer, who is not fully briefed and can offer the physician little information other than the fact that he or she has replaced the transporting officer. Delays in seeing physicians caused by the increasing numbers of patients presenting in emergency rooms for psychiatric evaluation necessarily means that physicians are more and more frequently relating to a second police officer, much to the consternation of physicians and police and to the detriment of seriously mentally ill patients.

Police officers, expressing their own frustrations, note that often come to the psychiatric emergency room frequently and with the same persons, only to have the individuals turned away from the hospital and re-released to the streets. The cycle then repeats.

This perception of high rates of use of psychiatric emergency room facilities by certain groups of patients is accurate. In interviews for the Commission's Admission and Discharge report cited above, an attending physician conducting research in Kings County Hospital Psychiatric Emergency Room reported that in October, 1987, 16 percent of the 1,040 patients seen in the psychiatric emergency room returned within six weeks for another evaluation. Similarly, 23 percent had been seen at least once before during the prior three months. These figures were up from 1986, when 19 percent of the patients had been seen within the previous three months and 12 percent within six weeks.

Again, this pattern of usage suggests the need for expanded clinic hours and crisis services available through outpatient

departments where many of these patients are known. In the particular case of Mr. Peteros, staff members from the Mapleton Clinic could have made a home visit during the middle of December, when he missed four consecutive appointments and was described by his mother as not sleeping and packing to leave. They did not.

Kingsboro Psychiatric Inpatient Stay

Mr. Peteros's inpatient treatment at Kingsboro Psychiatric Center from November 12 - December 2, 1987 was most seriously flawed by the failure of the Community Support Services case manager to initiate and sustain meaningful contact with him. CSS case manager services aim to ensure continuity and coordination of care among all support agencies and service providers, and to provide out-reach and support through home visits and community contacts. Mr. Peteros qualified for CSS case management services during the November 19 screening. Further CSS contact with the patient was not made until January 21, 1988 when Ms. E, the case manager, telephoned Mr. Peteros. He told her that, although he had missed his appointments with the psychiatrist at the Mapleton Clinic, he had seen a psychiatrist at the Kings County Hospital Outpatient Department who told him he needed no further psychiatric treatment. With this, he declined any further services from CSS. The case manager responded by closing Mr. Peteros's case.

The CSS treatment plan consisted of only the case manager's objectives and methodology: to establish a relationship with the patient, to visit the patient at least once a month on the ward, and to maintain communication with the primary worker (Mr. F at Kingsboro) as necessary. Ms. E also included in Mr. Peteros's diagnosis "mixed substance abuse; cocaine, alcohol." There is no indication from any source that this latter informa-

tion was true, nor any plan to deal with these additional problems.

In reviewing the obvious inadequacies of CSS services, records and interviews with supervising personnel revealed that no true plan of service had been developed, no services had been rendered (save one on-ward visit), the CSS worker had not participated in the patient's discharge and had not verified with the family, Kings County Hospital Outpatient Department, or the Mapleton Clinic any information the patient gave during the January 21 telephone conversation.

Further investigation revealed that the CSS case manager had been out on leave from November 29 to December 21, 1987. No one was assigned to cover her cases. Her supervisor reported he attended a team meeting and rounds on December 1 and 2, which included discussion of Mr. Peteros's imminent discharge. The discharge plan, not a collaborative effort, but rather the work of his primary therapist made no mention of CSS case management services. Despite suggestions from her supervisor, Ms. E failed to call the Mapleton Clinic to ensure that Mr. Peteros was cooperating with follow-up services. No rationale was offered to explain why the supervisor had accepted the deficient plan and had failed to ensure that reasonable attempts were made by the case manager to communicate with all involved parties.

As noted earlier, Mr. Peteros gradually responded to drug therapy during his stay at Kingsboro Psychiatric Center. During this time, his psychiatrist and medical doctor worked to meet his needs. Claiming he had AIDS when he was first admitted, Mr. Peteros was placed on blood and body fluid precautions until blood-work returned negative. His neurological exam was also negative and he gained a much needed 16 pounds. Dr. G, the psychiatrist ensured contact with the Mapleton Clinic therapist to learn Mr. Peteros's

treatment and medication history. He maintained contact with the family and met with them on November 18. Finally, Dr. G initiated Mr. Peteros's evaluation by the three member psychiatric board prior to discharge, in accordance with Kingsboro Psychiatric Center policy for patients admitted for assaultiveness.

In contrast to the close attention he received from medical personnel and his psychiatrist, Mr. Peteros was not seen for the the 30 minutes "individual supportive counseling" three times a week prescribed in his

treatment plan, as evidenced by the lack of any notes except a 72-hour review note by his primary therapist, Mr. F. In addition, Mr. F's social assessment of Mr. Peteros was incomplete, as noted by the chart deficiency list prepared by Kingsboro Psychiatric Center's Medical Records Department. The assessment gave a poor social history and no exploration of his relationship with his mother, although he was admitted subsequent to an altercation with police following an incident with her.

Recommendations

1. The Commission recommends the phase-out of the tripwire and diversion procedures as soon as possible. In order to facilitate this goal, the Commission recommends that OMH provide substantial technical assistance to Health and Hospitals Corporation (HHC) hospitals to ensure that patients no longer requiring acute care are placed in more appropriate settings. We recognize the success of the placement team headed by OMH staff in recently screening 122 HHC patients and placing nearly 80 and advise that these or similarly experienced staff be made available to train and guide HHC staff to ensure this movement continues. At the same time, HHC facilities need to examine their own staffing needs to better comply with the requirements of sound clinical practice, as well as State laws, governing appropriate discharge planning.
2. The Commission supports OMH's plan to expand community residence beds over the next ten years to accommodate 16,000 persons and the OMH intensive case management initiative. In addition, the Commission recommends that OMH assure, on a regional basis, the capacity of out-patient programs to provide extended hour clinic services, to provide crisis services both on site and through mobile units, to provide family and in-home support and to provide meaningful followup, including home visits for patients who fail to keep appointments and who are likely to be decompensating.

The Commission recognizes that OMH has reviewed the status of psychiatric

emergency services in municipal and State hospitals in New York City and has developed both short-term strategies to alleviate the overcrowding and a multi-year plan to restructure emergency services. The Commission supports implementation of the strategies identified, which would return psychiatric emergency rooms to their proper use and would provide detoxification beds and supportive housing for the mentally ill chemically dependent population. Specifically, OMH has identified three levels of emergency psychiatric services. In addition to the generic hospital-based programs, these include Specialized Emergency Services, licensed by OMH, providing specialized emergency programs and Comprehensive Emergency Services, licensed jointly by OMH and DOH, providing crisis stabilization, crisis outreach, crisis residence and assessment/referral/diversion.

- **Crisis Stabilization.** Provides intensive crisis intervention, including rapid tranquilization in order to reduce acute symptoms and restore individuals to their pre-crisis level of function. Includes the use of emergency room beds for up to 72 hours. May be provided in a clinic or a hospital setting licensed for psychiatric emergency services.
- **Crisis Outreach.** A mobile, crisis intervention service, as an extension of a crisis stabilization unit, aimed at off-site screening and acute symptom reduction. Responds to calls in natural and other provider (e.g., residential) settings.

- **Crisis Residence.** A 24-hour crisis intervention program providing acute symptom reduction and the restoration of individuals to their pre-crisis level of functioning. May be provided in specialized community residences or emergency room holding beds. May include short-term shelter residences associated with partial hospitalization programs.
 - **Assessment/Referral/Diversion.** The evaluation of persons in crisis in order to ascertain their current (and previous) level of functioning, health history, potential for dangerousness, precipitating events, and availability of social supports. The aim is to link the client to providers appropriate to his/her immediate needs and prevent unnecessary use of inpatient, emergency, or excessively restrictive program levels.
3. Although the Department of Health (DOH) issued Regulations for the operation of emergency rooms in 1987, these regulations did not address the psychiatric emergency rooms. The Commission recommends that DOH, in consultation with OMH, develop specific standards for psychiatric emergency rooms which include staffing standards. The requirement that each psychiatric emergency room develop a consistently dependable system for in-house record retrieval should also be included in the operating standards.
 4. The Commission recommends that, following an inpatient stay, a summary of treatment be sent to the provider of outpatient clinical services and the case manager. Similarly, when patients are treated in psychiatric emergency rooms and released, this information should be communicated to the outpatient services provider and case manager. Outpatient clinics must assume responsibility for taking reasonable measures to follow-up when patients fail to keep appointments.
 5. The Commission recommends that the Office of Mental Health and the Health and Hospitals Corporation develop with NYC police a protocol to ensure that physicians can secure specific detailed information about the circumstances under which a patient is brought to the psychiatric emergency room. This might include a procedure whereby physicians can get this information directly from the precinct.
 6. The Commission supports the results of Kings County Hospital's internal review of this case and its identification of the lack of social work notes in the case records of one-third of patients on diversion. The Commission also supports the Kings County Hospital recommendation to consolidate the Emergency Room and hospital records under the control of Medical Records, making them available on a 24-hour basis.
 7. The Commission found that both South Beach Psychiatric Center and Kingsboro Psychiatric Center failed to comment on several important issues when investigating the performance of their facilities in providing care to Mr. Peteros. South Beach Psychiatric Center's review of the care provided to Mr. Peteros by the Mapleton Clinic failed to note staff's failure to secure the patient's Kingsboro inpatient record and also failed to examine the clinic's limited response (telephone calls) when Mrs. Peteros was asking them on February 1, 1988 for assistance in getting her son back into treatment. Although the clinic lacks a formally designated crisis service, the Deputy Director of Treatment Services noted that the clinician arrange a home-

visit. The Commission recommends that South Beach Psychiatric Center review the clinic's guidelines for home visits, the number performed and under what circumstances, in an effort to ensure that the clinic is addressing the needs of its patients.

Although the Kingsboro Psychiatric Center review of the care provided during Mr. Peteros's inpatient stay resulted in a number of recommendations for changes in the operation of the liaison team (CSS case

managers), it failed to comment on the performance of the case manager and supervisor in this case. Such a review is indicated. Additionally, the revised procedures for the team should include a description of the outreach efforts which must be made before a case may be closed based on the patient's lack of cooperation. The failure of Mr. Peteros' primary therapist to document any supportive therapy as prescribed by the treatment plan also requires review.



RICHARD C. SURLLES, Ph.D., Commissioner

January 4 , 1988

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

Dear Mr. Sundram:

I have reviewed your confidential draft of the Commission's report on the treatment of Armando Peteros in Kings County Hospital Psychiatric Emergency room. My preliminary comments are as follows:

RECOMMENDATIONS:

1. We concur with CQC on the undesirability of the New York City Tripwire Agreement. We are actively pursuing phasing-out the tripwire and are in the process of developing a position paper for executive review. Such a position paper shall outline alternatives to tripwire and OMH's assumption of more intermediate care responsibility in exchange for a reduced role in providing acute care in New York City. Concurrently, the New York City Regional Office has developed a placement/discharge team similar to the concept implemented in the Target 100 Project in the Spring of 1988.
2. While we are pleased with the support from CQC for expansion of community residence beds over the next ten years, we are cognizant of the current fiscal restraint of future bed development. OMH is in the process of reviewing outpatient programs operated between State and voluntary providers to ascertain their role in the provision of essential services to the Seriously and Persistently Mentally Ill (SPMI) population in the community.

OMH is very encouraged by CQC's support for comprehensive psychiatric emergency services.

3. OMH continues to discuss with the Department of Health the possibility of developing service standards for the comprehensive psychiatric emergency services. The joint DOH/OMH emergency room study, conducted during November and December 1988, should provide additional information for the development of service standards.
4. and 5. OMH considers appropriate and timely communication of patient treatment between providers an essential component of continuity of care and has reinforced this policy direction through the Chief Medical Officer.
6. Through internal quality assurance efforts, OMH will continue to monitor Kings County Hospital's implementation of the plan of correction.
7. Both South Beach and Kingsboro Psychiatric Centers have been given a copy of the CQC report. Their response is pending.

Additionally, our Chief Medical Officer has arranged for a consultant to review the case and we will be sharing these findings and recommendations with you.

I have asked Drs. Sandra Forquer and Alice Lin to be responsible for following up on the issues identified in the report. Please feel free to contact them with any additional inquiries.

Sincerely,



Richard C. Surles, Ph.D.
Commissioner



NEW YORK STATE
OFFICE OF MENTAL HEALTH

KINGSBORO PSYCHIATRIC CENTER

PATRICIA A. ROACH, M.P.H.

Executive Director

Richard C. Surles, Ph.D., Commissioner

December 30, 1988

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

RE: [REDACTED]

Dear Mr. Sundram:

The following comments are being provided in response to recommendations made regarding Kingsboro Psychiatric Center in the Commission's Confidential Draft report on treatment of Armando Peteros* in the Kings County Hospital Psychiatric Center Emergency Room.

Specifically, it was noted that Kingsboro Psychiatric Center failed to comment on the performance of the Case Manager and Supervisor of the Liaison Team who were involved in this case. Also, the revised procedures for the team should include a description of outreach efforts which must be made before a case may be closed. Finally, Mr. [REDACTED] Primary Therapist on the inpatient unit failed to document the supportive therapy described by the Treatment Plan.

Kingsboro Psychiatric Center's review of the course of Mr. [REDACTED] hospitalization called attention to a need for clarification of the policy that guides the Liaison Team.

The corrective plan developed as the outcome of this review addressed the issue of supervision of the Case Managers and defined more precisely procedures for maintaining contact with clients and monitoring their status. The conditions for terminating contact with clients were also closely specified.

It was felt that such a clarification of policy was, first of all, necessary to support the critical transitional services to our patients that the Liaison Team provides. It clarified a standard for the team's functioning and an expectation of performance that will be used to evaluate the team.

*Pseudonym for patient [REDACTED]

DECEMBER 30, 1988

These issues were reviewed with the Case Manager and Supervisor who were involved with Mr. [REDACTED] case, as with other members of the Liaison Team, as part of their supervision, to establish a baseline of understanding of the requirements of their liaison function.

The corrective action taken was the redefinition of the Liaison Team operation as a system of intervention. It was not intended to identify specific individuals for disciplinary action at this time, but such action could be expected in response to any subsequent breach of policy.

With respect to the failure of Mr. [REDACTED] Primary Therapist to document any supportive therapy, an in-service training program on Treatment Plan documentation is scheduled to begin in the first quarter of 1989. All Primary Therapists will participate in this program, which will be conducted and supervised along professional discipline lines by the Department Heads of Psychology, Social Work and Rehabilitation.

Please note that the amended policy for the Liaison Team was attached to the Special Case Review report that was sent to Mr. Stephen Hirschhorn on June 16, 1988. This material is enclosed for your review.

Sincerely,



Patricia A. Roach, M.P.H.
Executive Director

PAR/ddc

Enclosure

cc: Dr. Lin
Dr. Curry
Mr. Evans
Mr. Shimono
Ms. White
Mr. Leiman
Ms. Hylton



NEW YORK STATE
OFFICE OF MENTAL HEALTH

KINGSBORO PSYCHIATRIC CENTER
PATRICIA A. ROACH, MPH
ACTING EXECUTIVE DIRECTOR

RICHARD C. SURLES, Ph.D., Commissioner

~~June~~
July 16, 1988

Mr. Stephen Hirschhorn
Review Specialist
Commission On Quality of Care
For the Mentally Disabled
80 Maiden Lane
New York, New York 10028-4811

RE: [REDACTED]

Dear Mr. Hirschhorn:

Enclosed is the report you requested of the review done at Kingsboro Psychiatric Center on the above named.

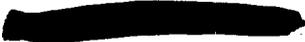
Please note that this was a Special Case Review rather than a Psychological Autopsy, the latter designation being reserved for reviews of suicides or suicide attempts.

Sincerely,


David Leiman
Quality Assurance

DL:cj
Attachment
cc: Ms. Roach (w/o attach)

SPECIAL CASE REVIEW


4/13/88

PRESENTING: ALPHONSO DANCE, CRC
PRIMARY THERAPIST

CHAIRPERSONS: DAVID LEIMAN
QUALITY ASSURANCE
RAGHU MITRA, M.D.
DIRECTOR OF RESIDENT TRAINING

ATTENDING: LESTER J. SCHAD, PhD - Director for Admissions
WYNETTA J. MORRISS, R.N. - N.A. Days
DEZELLA HUBBARD, TTL
DIANE WHITEHURST, PSW
DOROTHY SHIVERS, MHTA
PRATISHA KAUL, M.D.
SADHANA SARDANA, M.D.
DENNIS SCIMONE, PSW II, Liaison Team
SEMYON ERLIKH, M.D.
ARUNA AGNI, M.D.
MARY GLOVER, SWA II
JUDITH BEER, TTL
SHOBHANA M. PARIKH, M.D.
BERTHOLET DESIR, M.D., CHIEF MEDICAL OFFICER
RAYMOND PAULSON, SW II - Liaison Team

/lyn

ASSESSMENT/ASSESSMENT CONTINUATION SHEET

[REDACTED] 147 465

SPECIAL CASE REVIEW

Type of Assessment

DOB: 10/29/50

DX: SCHIZOPHRENIA CHRONIC PARANOID

DOA: 11/12/87 DOD: 12/2/87

KINGSBORO PSYCHIATRIC CT. AAU/006

CC #: 147 465

DOB: 10/29/50

DOA: 11/12/87

DOD: 12/2/87

DIAGNOSIS: SCHIZOPHRENIA, CHRONIC PARANOID TYPE

DESCRIPTION

This was the first admission to KPC of a 37 year old single white male. Patient was admitted on a 9.39 legal status on 11/12/87, on diversion from Kings County Hospital. Hospitalization was necessary and indicated because of agitation, responding to internal stimuli and dangerousness to himself and others. Patient had a history of one previous psychiatric hospitalization at Downstate Medical Center in 1981. Patient had been attending the Mapleton OPD (South Beach P.C.) for approximately seven years prior to his admission for therapy and medication. Not long prior to admission patient's medication had been gradually reduced and discontinued by the doctor at the OPD. Patient's parents telephoned the police because patient had become verbally abusive toward them and attempted to punch his elderly mother. When the police entered patient's home, he attacked them with a butcher knife.

COURSE OF TREATMENT

On admission, patient was extremely agitated and appeared to be responding to internal stimuli. While waiting for admission in the screening room, patient broke the door and ran out in an attempt to escape. He was brought back by ward staff and Safety and immediately sent to ward 006 and placed in restraints.

Patient's behavior was threatening with gesturing, distorted facial expressions and laughing inappropriately. Patient was placed on Thorazine 200 mg po - 9:00 am, 1:00 p.m. and 300 mg po HS (11/16/87) and Thorazine 300 mg TID on 11/23/87. Patient was

PAGE

1

ASSESSMENT/ASSESSMENT
CONTINUATION SHEETPatient's Name (Last, First, M.I.)
[REDACTED]

initially placed on Level I (11/12/87) for observation. After two days (11/14/87) patient's level was changed to Level III and on 11/18/87 patient's level was increased to Level IV.

Once patient was stabilized he was friendly and cooperative and generally quite pleasant. He tended to isolate himself from the patients although he was cooperative with staff.

PLAN FOR DISCHARGE

By the second week after admission the team indicated that patient had improved and we could start planning for discharge. A discharge planning session was held with patient, his mother and father, primary therapist - A. Dance, CRC, and psychiatrist, Dr. Parikh, M.D. Patient's family agreed that patient had made significant improvement and could return to live with them and attend outpatient treatment. It was recommended and agreed upon in the session that individual therapy and medication in an OPD was necessary for patient's stability and continued improvement in his mental health. The need for case management services was established and a request made for a case manager to be assigned to this case for OPD linkage and financial assistance. A Three Psychiatrist Board was convened and patient was cleared by the Board and recommended for: (1) Discharge to go home; (2) Maintenance Neuroleptics; (3) Refer to an OPD for follow-up care. Patient was referred to: Mapleton Clinic, 1650 Co Island Avenue, Brooklyn, N.Y. Appointment - 12/7/87 at 2:00 pm to see Dr. Crawford.

INCIDENT

On 3/2/88 it was reported in the N.Y. Times that on 2/26/88 Mr. [REDACTED] had stabbed his elderly parents to death.

DISCUSSION

The discussion indicated that although patient had been extremely agitated, threat-

PAGE

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ASSESSMENT/ASSESSMENT CONTINUATION SHEET

SPECIAL CASE REVIEW

Type of Assessment

Patient's Name (Last, First, M.I.)

"C" No.

Unit/Ward No.

Facility Name

ening and required restraints upon admission, he responded quickly to medication.

Following the initial incident patient showed no evidence of violent or threatening behavior on the unit.

A discussion of the patient's history revealed that there was one prior hospitalization at Downstate Medical Center in 1981. From there he was referred to the Mapletown OPD (South Beach P.C.) where he was attending regularly for the past seven years.

Reportedly his medication was being tapered off by the clinic and was discontinued in October 1987.

It was noted that patient's parents were extremely supportive, going out of their way to visit him and were eager for him to return home to live with them once he was stabilized. The Liaison Team opened a case for this patient on 11/13/87 and a case manager was assigned. The Liaison Team was to assure clinic linkage following patient's discharge and in this case there was also a need to help patient obtain financial support. Discussion also indicated that patient's problems were appropriately addressed and treated during his treatment on the unit. Prior to discharge patient was examined by a board of three psychiatrists who cleared him for discharge. Clinic referral was appropriate and within five days of his discharge.

The issue arose regarding patient's linkage to the OPD following his discharge.

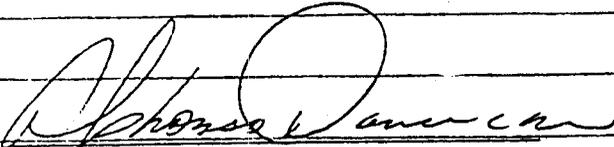
Although a case manager was assigned to the case, she was out ill at the time of discharge. Because of this there seemed to be a breakdown of service and the first note by the case manager in the chart is dated 1/27/88 and indicates the patient failed to keep his OPD appointment. Dennis Scimone, manager of the Liaison Team indicated that a system has been put in place to insure that cases are picked up if an assigned worker is unavailable.

Patient's Name (Last, First, M.I.)

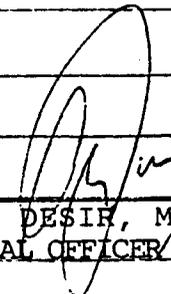
ASSESSMENT/ASSESSMENT
CONTINUATION SHEET

SUMMARY AND CONCLUSIONS

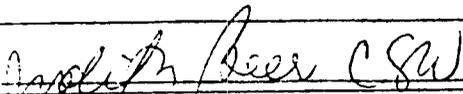
It was concluded that patient's treatment on the inpatient unit was effective including the discharge planning and referrals to OPD. The discussion also indicated that the incident was not predictable or preventable based on the unit's treatment efforts and contact with the family. The main issue that emerged from the discussion was a need for a modification of the Liaison Team's policy to properly insure coverage of assigned cases. The plan developed to address this is attached.



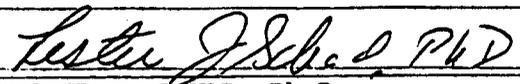
ALPHONSO DANCE, CRC
PRIMARY THERAPIST
PRESENTER



BERTHOLET DESIR, M.D.
CHIEF MEDICAL OFFICER



JUDITH BEER, CSW
TREATMENT TEAM LEADER



LESTER J. SCHAD, Ph.D.
DIRECTOR FOR ADMISSION

/lyn/cj
4/88

May 5, 1988

LIAISON TEAM

DESIGNATION OF HIGH RISK CASES

PROCEDURES

- All cases with histories of suicidal or assaultive behaviors are to be designated as "high risk" cases.
- Historical information regarding past suicidal or assaultive behavior will be acquired by unit supervisors during their attendance at ward team meetings when patients are referred for casemanagement services.
- Supervisors will report this information to the casemanager upon assignment of the case for services.
- Supervisors will concurrently flag the charts of high risk cases with assistance from the secretarial staff. Blue stars indicate assaultive histories. Red stars indicate suicidal histories. This will enable these charts to be outstanding in order to immediately alert staff to the status of the case.
- High risk cases always require closer monitoring and follow-up by case management staff.
- Any decompensation in the patient's condition, non-compliance with treatment, or questions about their suicidal or assaultive potential are to be presented to the casemanager's supervisor immediately. The Chief Medical Officer or his designee will then be notified.
- Supervisors will direct the casemanager regarding the appropriate intervention to be performed. If indicated, the supervisor will accompany the casemanager to visit the patient in order to provide professional assessment of patient's condition and to determine the appropriate follow-up that is needed.
- In these situations, the casemanager supervisor must then report to the Unit Manager regarding the status of the patient's condition and for consultation concerning the appropriate interventions that are to be performed. The Chief Medical Officer or his designee are available for consultation.
- Patients in the high risk category are subject to review by the Chief Medical Officer or his designee.

Addendum:

If a casemanager learns any information regarding a patients history concerning suicidal or assaultive behaviors, this is to be reported to their supervisor and documented in the case record. The case should then be designated as a high risk case if this designation was not previously made. This should be reported immediately to the Unit Manager who in turn will notify the Chief Medical Officer or his designee of this.

LIAISON TEAM

Case coverage procedures during staff absences for both scheduled and unscheduled leave.

I When a staff member is to be absent:

- They must immediately notify their supervisor of any cases on their caseload that will require staff coverage during their absence.
- The supervisor will arrange staff coverage for the cases identified.
- The supervisor will assume responsibility for the remaining cases on their caseload if any unexpected need for staff coverage should arise.

II When a staff member is absent for more than 3 days:

- They must review their entire caseloads with their supervisor
- The staff member and supervisor will determine the type of coverage or interventions that are indicated.
- The supervisor will arrange staff coverage for all the cases on their caseload.
- The supervisor will assume case coverage responsibility for any cases that are not re-assigned to other staff for coverage.
- An outline of case coverage arrangements is to be submitted by the supervisor to the Unit Manager for review and approval.
- High risk cases should also receive special consideration for more intensified case coverage (e.g. frequent telephone monitoring).

III If a staff member is absent and is unavailable to report directly to their supervisor due to an emergency or serious illness:

- The supervisor will notify the Unit Manager immediately of this situation.
- The Unit Manager and supervisor will jointly arrange and coordinate the appropriate case coverage.

Procedures For Liaison Team Termination Of Cases

The following outline provides the conditions, under which a case can be approved for termination on the Liaison Unit:

- a) When patient has been linked (admitted) to a community based clinic and provision of all case management services have been completed.
- b) If a patient refuses casemanagement services and rejects outreach efforts by casemanagers. Such as home visit (s), telephone contacts and letters.

Prior to the closing of the case, a letter will be sent to the patient and their immediate family informing them of the appropriate agency that can provide treatment services to them.

- c) If a patient cannot be located after the following combination of outreach efforts have been made; home visit, attempts to contact significant others and a telegram or letter has received no response.
- d) If a patient has been transferred to a KPC intermediate care unit or has been transferred to the inpatient unit of another facility.

This is to confirm the recently implemented procedural changes for supervisory review and approval of cases submitted by casemanagers for termination.

- Weekly review of cases submitted for termination. Reviews will be conducted by the Casemanager Supervisor in consultation with the Unit Manager, Fridays from 3:00 - 4:00 p.m.
- When the Casemanager Supervisor approves a case for termination, they are to indicate this by providing a supervisory review statement below the casemanager's termination note with their signature. This must also be documented in our unit's AAU admission log as per procedure.

cc: B. Evans
Director of Community Services



STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

DAVID AXELROD, M.D.
COMMISSIONER

December 14, 1988

Dear Chairman Sundram:

Thank you for providing me with the Commission's draft report on the treatment of Armando Peteros in Kings County Hospital Psychiatric Emergency Room. This a sobering document. Please know that we share your concerns for the quality and continuity of care provided to psychiatric patients in emergency rooms of municipal hospitals.

In response, on an emergency basis, we have approved the expansion of inpatient bed capacities at several of the Corporation's facilities. Also, the Department has consistently encouraged the New York City Health and Hospitals Corporation to work with other state, city and provider groups toward a long-term solution for the too frequent over-census problem in this service area.

With regard to the third recommendation in this report, this Department is working with the Office of Mental Health to develop standards for psychiatric emergency services in acute care hospitals. You should also be aware that Department of Health regulations which become effective on January 1, 1989 contain an explicit requirement in Section 405.19(c)(7) of 10NYCRR, Emergency Services that there "shall be a medical record that meets the medical record requirements of this Part for every patient seen in the emergency service. Medical records shall be integrated or cross referenced with the inpatient and outpatient medical records system to assure the timely availability of previous patient care information and shall contain the pre-hospital care report or equivalent report for patients who arrive by ambulance."

Thus, I believe that the Department is taking appropriate steps to assure more adequate services for psychiatric patients in hospitals, and to prevent human tragedies like the one described in your draft report.

Sincerely,

David Axelrod, M.D.
Commissioner of Health

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



NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

125 Worth Street • New York, New York 10013

JO Ivey Boufford, M.D.
President

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

January 24, 1989

Clarence J. Sundram
Chairman
New York State Commission on the Quality
of Care for the Mentally Disabled
99 Washington Avenue
Albany, New York 11210

Dear Mr. Sundram:

I have read with interest the Commission's very thorough and balanced report on the care and treatment of [REDACTED]. Please accept my apologies for the delay in providing this response.

Although I have been advised by Counsel to avoid commenting on the specifics of this tragedy, I can say, without qualification, that the Commission's observations and recommendations regarding the broader mental health service system issues and their impact on this case are fair, accurate, and consistent with those put forth by the Health and Hospitals Corporation over the past several years.

As you will note in the attached letter to Commissioner Surles, HHC is particularly concerned about the role that Kings County Hospital plays in this overstressed system in Brooklyn. Negotiations are now occurring with SOMH and the Governor's office in an effort to ensure much needed relief for this distressed facility.

Given the unprecedented impact of alcohol, drugs, especially crack, and homelessness among the mentally ill, and the absence of viable, responsible service alternatives, the HHC's emergency rooms have become the first, and sometimes the only option of treatment for the seriously mentally ill. As you correctly suggest in your report, these over-utilized emergency rooms are attempting to fulfill roles never intended for them, and faring poorly in that effort. It is therefore essential that the

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QUALITY OF CARE

poorly in that effort. It is therefore essential that the development of those service alternatives designed to decrease this relentless demand for emergency room services be given the highest priority by policy makers, providers and advocates alike.

HHC is committed to the pursuit of such alternatives, and in Brooklyn alone we are developing a crisis clinic with extended hours and a mobile outreach (home visit) capacity at KCHC, a comprehensive managed care program for 100 heavy system users in South Brooklyn at Coney Island, and a specially designed shelter based continuing treatment program for the homeless mentally ill sponsored by Woodhull. The Corporation is also most interested in having at least one of its hospitals serve as a pilot facility for the SOMH comprehensive emergency services initiative during the upcoming year.

Related to drug involved patients, HHC is also expediting the development of new drug detox beds at Harlem and KCHC, and we are launching a MICA/crack abuse ambulatory service at Bellevue and a shelter-based continuing treatment program for homeless MICA's at the 30th Street Shelter in Manhattan. However, residential drug free treatment programs for our drug compromised patients are most desperately needed, and for this service, the Corporation must turn to DSAS and its network of established and experienced providers for additional service availability and accessibility by municipal hospital referrals.

We are also hopeful that the long awaited intensive case management initiative will have a positive impact on our collective efforts on behalf of the most seriously mentally ill. However, unless extraordinary efforts are made to more effectively integrate our seriously fragmented service system here in the City, these case managers, with all of their advocacy, commitment and expertise, will make only a marginal difference in the lives of these patients.

You may recall that HHC has been piloting a clinical patient tracking system at Harlem and Bellevue, designed to provide emergency room clinicians with the most complete and accessible information regarding a patient's treatment history and relevant risk factors. We are committed to the refinement and further expansion of this initiative.

Finally, you will be pleased to know that we are now negotiating with SOMH for an orderly phase down of the use of "Tripwire" transfers of emergency room patients from KCHC and all other municipal facilities. In order to accomplish this desirable end, we are asking that SOMH significantly increase our patients' current access to intermediate and long term institutional and community care as they proceed with the implementation of their com-

munity placement teams which you mentioned in your report.

I hope the above comments are helpful and reinforcing to the Commission's efforts to strengthen this State's mental health system for the care and treatment of the seriously mentally ill. Thank you again for the opportunity to review the draft of this sensitive, well focused and very important report.

Sincerely,

A handwritten signature in black ink, appearing to read "Luis R. Marcos". The signature is written in a cursive, somewhat stylized script.

Luis R. Marcos, M.D.

LRM:mye
Attachment

cc: Jo Ivey Boufford, M.D.
Sara L. Kellermann, M.D.



DEPARTMENT OF MENTAL HEALTH
MENTAL RETARDATION AND ALCOHOLISM SERVICES

93 WORTH STREET
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TEL. 566-4830

SARA L. KELLERMANN, M.D.
COMMISSIONER

December 16, 1988

Clarence J. Sundram
Chairman
NYS Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue - Suite 730
Albany, New York 12210

Dear Mr. Sundram:

I am writing in regard to the draft of the Commission's Report on the treatment of Armando Peteros (a pseudonym), in Kings County Hospital Center's Psychiatric Emergency Room.

The report appears to be complete, well written and thoughtful in its conclusions. It focuses not only on the individual problems encountered at each involved facility, but also on the more systemic problems of overcrowding, inpatient gridlock, the dilemma of the dually diagnosed, staff shortages and the lack of discharge options.

With regard to your first recommendation concerning the phase-out of the tripwire and diversion procedures, while the Department agrees that these measures are far from ideal, it is important to remember that conditions in emergency rooms would be significantly more dysfunctional if such emergency measures were not available. Before the phase-out of these emergency measures, other alternative service components must be available, together with access to intermediate care on a no decline basis, where appropriate.

Thank you for sharing the Commission's draft report with the Department.

Sincerely,

Sara L. Kellermann, M.D.
Commissioner

SLK/mjc