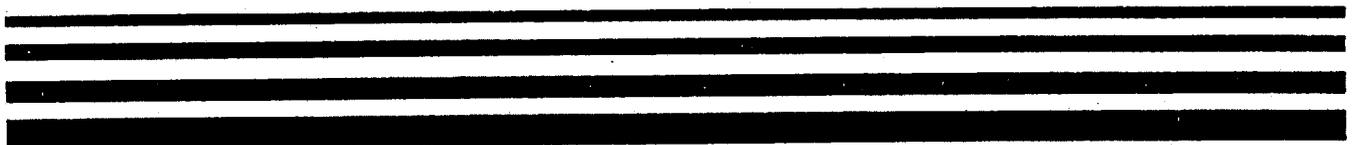


# In the Matter of Michael Goldstein: An Emergency Room Patient Discharged by Genesee Hospital

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



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**In the Matter of Michael Goldstein:  
An Emergency Room Patient  
Discharged by Genesee Hospital**

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**Clarence J. Sundram  
CHAIRMAN**

**Irene L. Platt  
James A. Cashen  
COMMISSIONERS**

**June 1991**



**NYS COMMISSION  
ON QUALITY OF CARE  
FOR THE MENTALLY DISABLED**

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# Preface

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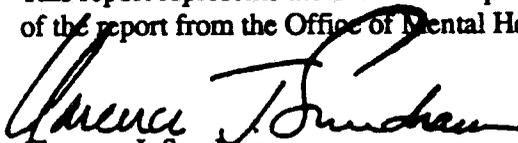
The evaluation of patients with symptoms of mental illness presenting at emergency rooms and the determination of the need for involuntary inpatient psychiatric treatment is an enterprise fraught with risks. While history makes clear and mental health professionals acknowledge that it is impossible to predict accurately the likelihood of violence toward self or others presented by any specific patient at any particular time, such lack of certainty should not preclude psychiatrists and other mental health professionals from taking reasonable steps to minimize the risks.

As this report details, the Commission has investigated several cases where tragedies ensued when prospective patients were released from emergency rooms following a decision not to admit them. The details of each tragedy are different—in some cases, the prospective patients killed themselves; in other cases, they allegedly killed loved ones; in still other cases, they allegedly killed randomly. Nonetheless, one of the common characteristics in all of these tragedies is that the patients were not personally evaluated by experienced psychiatrists.

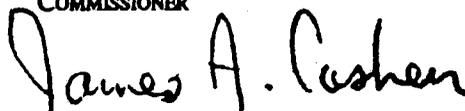
The subject of this report, following a lengthy stay in the emergency room at Genesee Hospital, during which he reported hearing voices telling him to kill himself and other people, was released with medication and, within several hours, allegedly killed two men. During the emergency room evaluation, he was seen by two Psychiatric Assessment Officers (Masters level social workers with several years experience) who conferred by phone with the psychiatrist.

The Commission recognizes the validity of the claim that limited personnel resources do not permit everyone brought to the emergency rooms for psychiatric evaluation to be seen by a psychiatrist. For precisely this reason, the Commission recommends in this report that the professional psychiatric community, under the leadership of the Office of Mental Health, provide specific guidelines to clearly identify which patients, by virtue of their symptomatology, history, or other circumstances, must be personally seen by an experienced psychiatrist before they are released from emergency rooms. The Office of Mental Health has agreed that such guidelines are warranted and is presently gathering opinion on their content and studying implementation strategies.

This report represents the unanimous opinion of the members of the Commission. Responses to a draft of the report from the Office of Mental Health and Genesee Hospital are attached as appendices.

  
Clarence J. Sundram  
CHAIRMAN

  
Irene L. Platt  
COMMISSIONER

  
James A. Cashen  
COMMISSIONER

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# Staff Acknowledgements

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# Introduction

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The Commission is sometimes called on to examine the care provided to mentally ill persons under evaluation for inpatient admission.

Pursuant to its responsibility to ensure that high quality care is provided to mentally disabled persons (Mental Hygiene Law §45.07, subd. (a)), the Commission is sometimes called on to examine the care provided to mentally ill persons under evaluation for inpatient admission. Often these cases attract public attention because of the tragedies associated with them.

In July 1986, just two days after he was discharged following a prolonged evaluation in the Emergency Room of a New York City hospital, a patient attacked passengers on the Staten Island Ferry with a sword, leaving two persons dead and several others wounded. The report of the Commission's investigation (*Investigation of the Care and Treatment Provided to Juan Gonzalez by Presbyterian Medical Center Emergency Room July 3-5, 1986*) revealed a number of deficiencies in the care provided, most importantly a lack of involvement by senior psychiatric staff in the evaluation and treatment of this patient.

The Commission's report revealed that the decisions regarding Mr. Gonzalez' care and his eventual discharge were made by a third year resident who had less than a week's experience in the Emergency Room, and by other residents who failed to conduct a physical examination, obtain a medical history or perform a drug screen. Despite the patient's clearly serious psychiatric symptoms, including hallucinations and delusions, and the patient's consent for voluntary inpatient psychiatric admission, the residents discharged Mr. Gonzalez when their attempts to locate a vacant psychiatric bed for him proved futile. These and other deficiencies in care were not detected or corrected at the time by senior psychiatric clinicians who were responsible for supervising the residents, as no senior clinical staff examined the patient during his stay in the hospital's Emergency Room.

In 1988, another tragedy was depicted in a Commission report *Psychiatric Emergency Room Overcrowding: A Case Study*, when Armando Peteros (a pseudonym) allegedly murdered his elderly parents 10 days after the last of several psychiatric emergency room evaluations. That report graphically presents the stresses encountered in an overcrowded ER. Twelve patients were waiting for beds and others were still being evaluated. This produced conditions which resulted in the disregard of standard procedures. For example, physicians failed to complete records, failed to document important telephone contacts with the family and did not write a discharge plan. ER staff did not locate the records of other recent ER evaluations. Placed into the midst of this over-burdened system was a psychiatrist who had run an inpatient unit, but who for the first time was being asked to evaluate patients for admission.

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system, especially at night and on weekends and holidays, are often the least senior, least experienced, and less trained professionals. This is not to suggest that if evaluations were done by senior psychiatrists, costly and tragic errors would not occur. Rather, they might be fewer and the specter of doubt would be reduced that, had a more seasoned or highly trained specialist done the evaluation, the decision might have been different. The cost of an error in judgement by less qualified clinicians can be high when the decision is not to admit an individual to an inpatient psychiatric facility. In some few cases these individuals will commit acts which are fatal or seriously injurious to themselves or others.

The subject of the present report again concerns the Commission's investigation of the psychiatric evaluation and treatment of a potentially violent patient in an emergency room shortly before he allegedly committed violent acts.

In October, 1990 the Commission learned that a man alleged by police in Rochester to have stabbed two persons to death had been brought to the Genesee Hospital Emergency Department just hours before the murders, following police involvement in a complaint of disturbing the peace at a local hotel. The patient had been pounding on guests' doors, and reported to police that he was looking for his father, who he claimed was the head of the CIA. This individual, Michael Goldstein,<sup>2</sup> reported that he was feeling suicidal and hearing voices telling him to kill people. Following the initiation of suicide precautions by the nurse, Mr. Goldstein was examined by an the Emergency Room physician, an internist, who concluded that the patient's problems were psychiatric in nature. Mr. Goldstein was interviewed by psychiatric social workers who discussed their observations with the on-call psychiatrist via telephone. Without personally examining him, the on-call psychiatrist prescribed psychotropic medication for Mr. Goldstein, and, following the social worker's report that Mr. Goldstein later stated the hallucinations had lifted, ordered his release from the Emergency Room. The police allege that a few hours later, without apparent motive, Mr. Goldstein stabbed to death two neighbors in the residential hotel in which they all lived.

Genesee Hospital's policies do not describe any circumstances which require that a psychiatrist personally examine the patient as part of the ER evaluation, nor does it specify any special procedures to be followed in evaluating potentially violent patients. Neither the regulations established by the Department of Health (governing Emergency Rooms) nor of the Office of Mental Health require such a policy.

The Commission recognizes that not every patient with a psychiatric problem who presents for evaluation in an Emergency Room can receive the attention of senior psychiatric staff, as the finite resources of the mental health system do not permit every hospital's emergency room to be staffed by experienced psychiatrists on a 24 hour basis. Further, the

The subject of the present report again concerns the Commission's investigation of the psychiatric evaluation and treatment of a potentially violent patient in an emergency room shortly before he allegedly committed violent acts.

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<sup>2</sup> a pseudonym

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# Chronology of Events

## October 7 and 8, 1990

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The following chronology and the background material have been compiled from extensive Commission interviews of Genesee Hospital staff and by reviews of Mr. Goldstein's Emergency Room and inpatient records.

Michael Goldstein arrived at the Emergency Room of Genesee Hospital via ambulance on October 7 at approximately 1:30 pm. He had been found at a nearby hotel knocking on doors, looking for his father. Mr. Goldstein told police that his father was "Gary" Webster, the head of the CIA. The police officers called an ambulance and Mr. Goldstein voluntarily agreed to go to the Emergency Room.

Mr. Goldstein was first seen at the Genesee Hospital ER by a Registered Nurse to whom he reported feeling suicidal. She placed him on suicide precautions and, per hospital policy, directed an aide to help him change into a hospital gown. Mr. Goldstein became resistant when asked to take off his pants. The aide asked a security guard to step into Mr. Goldstein's room and informed the patient that he would be placed in restraints if he did not cooperate. Mr. Goldstein then complied with the request to don a hospital gown.

The ER physician, an internist whose job it was to give patients' medical clearance, examined Mr. Goldstein who described feeling like wanting to kill himself and reported hearing voices telling him to kill people.

The ER physician, an internist whose job it was to give patients' medical clearance, then examined Mr. Goldstein who described feeling like wanting to kill himself and reported hearing voices telling him to kill people. During his brief interview, the ER physician was unsuccessful in eliciting further details about the voices or thoughts about killing people. He conducted a short physical examination and concluded the patient had no medical problems requiring immediate attention and that he should be evaluated by the psychiatric social worker serving as the Psychiatric Assessment Officer (PAO).

The PAO reviewed the ER face sheet on which the physician had recorded his notes, including a brief statement in a paragraph relating findings from the physical exam that the patient was hearing voices telling him to kill people. *The PAO did not see the note about the command hallucinations, and consequently did not inquire about them during her evaluation.* She conducted a 40 minute interview which included at least twice questioning Mr. Goldstein if he were experiencing thoughts or feeling about harming himself or others. He denied both suicidal and homicidal ideation, and reported hearing voices telling him to communicate various secrets to celebrities such as Robert DeNiro and Meryl Streep. Based on her examination, the PAO concluded that the

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# The Police Investigation

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The police investigation revealed no motive for the murders. Nothing was stolen from the victims' rooms and no other motive has been reported.

Police believe the first victim died of multiple stab wounds sometime shortly after midnight on the morning of October 8, 1990. A second victim, whose room was close to both Michael Goldstein's room and that of the first victim, was stabbed to death a few hours later. Police theorize that shortly after the second murder, while wearing a pair of blood stained shorts over sweatpants, Mr. Goldstein stole a truck and drove to a pharmacy to get his Stelazine prescription filled. He also went to a restaurant for breakfast, but was refused service. He then returned to the hotel where he lived (but not where he had been disturbing the peace earlier) in time to get onto the elevator with police detectives who had just arrived to investigate a report of a body. Mr. Goldstein accompanied the detectives to the murder scene and a uniformed officer, apparently acting on information from a witness, immediately placed him under arrest.

In addition to his reported confession, evidence against Mr. Goldstein reportedly included bloodstained clothing and the knife believed to have been used in the murders. A witness reportedly also heard one of the victims beg Mr. Goldstein not to kill him.

The police investigation revealed no motive for the murders. Nothing was stolen from the victims' rooms and no other motive has been reported.

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# Findings

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Three pertinent findings are immediately apparent in reviewing Mr. Goldstein's treatment at the Genesee Hospital Emergency Department:

- The psychiatrist who made the decisions regarding medication and disposition never personally examined Mr. Goldstein, but acted on information provided by the Psychiatric Assessment Officers and the ER physician.
- Mr. Goldstein's command hallucinations to kill himself and others were not adequately evaluated and were not reported to the psychiatrist who prescribed medication and ordered his discharge.
- The documentation in the ER record was, in part, not focused and not comprehensive.

The first deficiency represents a systemic weakness in the widely accepted policies and procedures of Emergency Rooms, which do not define the conditions under which it is necessary for a psychiatrist to personally examine patients during "off hours", e.g., holidays, weekends, nights. At Genesee Hospital, the psychiatrist on-call is required to be available to consult, typically by telephone, regarding patients with psychiatric needs who present in the ER.

ER staff and the on-call psychiatrist acknowledge that it is extremely rare for a psychiatrist to come to the hospital for a personal examination during "off" hours.

ER staff and the on-call psychiatrist acknowledge that it is extremely rare for a psychiatrist to come to the hospital for a personal examination during "off" hours. A nurse who has worked in the Genesee Hospital ER for three years could recall only a single instance in which the on-call psychiatrist had come in to attend a patient. Both the hospital administrators and their attorney defended the hospital by pointing out that this practice is widespread and represents the accepted professional standard.

As noted, the Commission investigation also revealed that Mr. Goldstein's command hallucinations were not adequately evaluated. Reasonable clinical practice would require that the patient's report of command hallucinations to kill be followed up with specific inquiry regarding the voices, e.g., what they are currently saying, what happened to the voices if he denied that they were presently telling him to kill people, and questions asking him to reconcile what he told the physician examining him for medical clearance with his discrepant reports to the PAOs. During Commission interviews and as they documented the treatment in the record, neither PAO undertook such a detailed evaluation of the command hallucinations.

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# Conclusions and Recommendations

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Although one can never state with certainty that the calamitous events would have been averted by a different evaluation process, the Commission believes that corrective measures are warranted to provide additional protections to patients and the community.

No conclusion is possible about whether the disposition decision for Michael Goldstein would have been different if the on-call psychiatrist had personally examined the patient or had been aware of the command hallucinations to kill himself and others. It is also too speculative to assume how Mr. Goldstein would have responded to follow-up questions about his report of command hallucinations. He might well have done what he did with the more generic questions asked by the PAOs to determine if he was either homicidal or suicidal, and simply responded negatively. In fact, the on-call psychiatrist claims that his decision would *not* have changed if he had known about the command hallucinations, since Mr. Goldstein reported that the auditory hallucinations had lifted and his repeated denials that he was experiencing suicidal/homicidal ideation indicated that the medication had been effective.

Although one can never state with certainty that the calamitous events of October 8 or the other tragedies described earlier in the report would have been averted by a different evaluation process, the Commission believes that corrective measures are warranted to provide additional protections to patients and the community.

To this end the Commission recommends:

- (1) OMH require all facilities operated by OMH, and OMH certified 9.39 hospitals (those certified to accept emergency admissions) to develop policies which specify the circumstances and patient profiles which require that an experienced psychiatrist conduct a personal examination of an Emergency Room patient being considered for admission prior to his/her discharge. These policies should require, at a minimum, that patients displaying behaviors which are likely to cause serious harm to themselves or others and those experiencing command hallucinations to harm themselves or others be examined by a psychiatrist.
- (2) In those hospitals, particularly where a psychiatrist is not always available on-site, the hospital carefully consider establishing a holding/observation bed where patients whose mental status is uncertain can be observed for up to 24 hours before a final decision to admit or discharge is made.
- (3) Genesee Hospital revise the forms for the documentation of psychiatric findings in the Emergency Room to specifically elicit and delineate critical information from the mental status exam. This should include, but not be limited to, the identification of the presence or absence of homicidal or suicidal command hallucinations.

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# Responses to the Draft Report

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Appendix I is the Office of Mental Health's response to this report, following discussion with the Commission addressing how best to ensure a psychiatrist's evaluation of a patient in an ER whose symptoms warrant it.

Appendix II is the Genesee Hospital's response to the Commission's draft report. The reader will note that, although both the Commission report and the Genesee Hospital response agree on the facts of what transpired on October 7, the Hospital disagrees with the Commission's conclusions regarding the adequacy of the mental status evaluations.

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**Appendix I**  
**Office of Mental Health Response**

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NEW YORK STATE  
OFFICE OF MENTAL HEALTH

44 Holland Avenue. Albany. New York 12226

RICHARD C. SURLES, Ph.D., Commissioner

April 8, 1991

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:

This is to follow up on our recent discussion on emergency services in general hospitals.

At the March 28, 1991 meeting between the Commission and Office of Mental Health (OMH), we discussed the Commission's draft report on the psychiatric evaluation of one patient at Genesee Hospital and OMH's role in monitoring emergency services in a general hospital setting. We also discussed the enforcement authorities of the Department of Health (DOH) and OMH. There was a general consensus that health and mental health professionals working in emergency services could use some guidance in practice standards, especially when making discharge decisions.

I have since reviewed the options available to us to improve and strengthen psychiatric services in general hospital emergency rooms.

I have asked John Petrila to conduct a review of our legislative authority under the 1988 legislative amendment pursuant to the 9.39 Mental Health Law, as well as the possibility of accessing the enforcement authority of the DOH--the latter seems to offer us a more expedient, less cumbersome tool for future monitoring.

As we discussed, John Oldham will call upon the American Psychiatric Association New York Chapter to develop general practice guidelines for psychiatric emergency screening. We expect to share the draft with a wider psychiatric community. Concurrently, Steve Scher will develop a similar work product as part of OMH's regulatory and licensing role with the Comprehensive Psychiatric Emergency Program.

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**Appendix II**  
**Genesee Hospital Response**

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224 ALEXANDER STREET, ROCHESTER, NEW YORK 14607

716 263-0800

Paul W. Hanson  
President

April 25, 1991

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

RE: The Genesee Hospital Response to Draft Commission Report on  
• [REDACTED] (pseudonym Michael Goldstein)

Dear Chairman Sundram:

Enclosed please find The Genesee Hospital's written response to the Commission's report sent March 14, 1991, in connection with the circumstances surrounding the psychiatric evaluation of the above-referenced patient known by the pseudonym Michael Goldstein.

Sincerely,

A handwritten signature in cursive script that reads "Paul W. Hanson".

Paul W. Hanson

PWH:bmm  
Enclosure



224 ALEXANDER STREET, ROCHESTER, NEW YORK 14607

(716) 263-6000

## HOSPITAL RESPONSE TO DRAFT REPORT

We have carefully evaluated the March 4, 1991 draft report of the Commission of the Quality of Care for the Mentally Disabled (CQC) on the psychiatric evaluation of a patient pseudonymously known as Michael Goldstein, and we are pleased to have been given the opportunity to comment on the draft.

Any time a psychiatric patient who was treated at our facility is charged with<sup>1</sup> involvement in such tragic events as those detailed in the report, we are as deeply concerned as the Commission with an investigation of the care he received at our facility.

We are pleased that the Commission found that the Hospital followed the regulations and requirements applicable to psychiatric patients presenting to the Emergency Departments of general hospitals.

The Hospital agrees with the Commission that it is too speculative to conclude that different actions on the part of physicians and Hospital staff would have resulted in a different outcome for the patient and the men who were found dead. Nevertheless, the Hospital has itself carefully examined the care

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<sup>1</sup>The Hospital notes that the patient has not been convicted of any crime. The Hospital must object to any assumption that the patient has committed the acts in question.

and psychiatrist discussed his previous hospitalization.

Third, in considering this patient's care, particularly in comparison to other patients mentioned in the draft report, it is important to note that Mr. Goldstein's evaluation was not a brief encounter. He was in the Hospital for over seven hours, during which time he was seen by a triage nurse, examined by an internist, his past records were reviewed, he was given a comprehensive mental status examination by a psychiatric social worker, medicated, and, after time elapsed, examined again not only by this social worker, but by an additional psychiatric social worker as well. In addition, the internist and both psychiatric social workers each consulted by phone with the on-call psychiatrist who was personally familiar with the patient from previous in-patient psychiatric hospitalizations at the facility.

Under the circumstances, the Hospital would request that the finding about what information the psychiatrist had when he prescribed medication be supplemented to include the above information.

Also, the Hospital would respectfully disagree with the finding that the patient's hallucinations were not adequately evaluated.

#### DETAILED CONSIDERATION OF REPORT

Mr. Goldstein was brought to The Genesee Hospital on Sunday, October 7, 1991, for evaluation of his psychiatric

The hallucinations were next probed as part of a comprehensive mental status exam conducted by a psychiatric social worker with five years experience as a Psychiatric Assignment Officer ("PAO") evaluating emergency room patients for admission.

The interview lasted thirty to forty minutes. The PAO had reviewed the patient's record of previous in-patient psychiatric care at the Hospital. Questions were asked about the auditory hallucinations. When asked whether the voices he heard were telling him to harm himself, the patient replied, "No." This question probes not just the content of the voices, but whether the voices were commanding the patient to act.

The patient described the content of the voices as telling him to give secrets -- nuclear, musical, and the like --to movie stars. The PAO questioned him about whether the voices were telling him to harm the stars - probing him specifically about command aspects of the hallucinations he described. He responded, "No."

The PAO documented, "Pt denies that voices tell him or that he has any thought plan or intent to harm himself or others."

The patient's manner and affect suggested some doubt to the PAO about whether Mr. Goldstein was hearing voices, but they did not suggest doubt about whether the hallucinations were more problematic than the patient was reporting. In other words, the non-verbal presentation of the patient was evaluated and found consistent with the non-lethal character of the hallucinations he

evaluation by the second PAO.

The second PAO had eight year's clinical experience, including therapy, crisis intervention and over a year's experience as a PAO in the Hospital's emergency department.

After reviewing the patient's records, including those of his previous in-patient stay, the second PAO conducted a mental status examination that lasted twenty to thirty minutes. She asked Mr. Goldstein about the voices he had been hearing, and the patient responded that they had "lifted." She asked him what the voices had said, and he told her they had talked of music and the movies. At her request, he elaborated further on the content, and she found nothing clinically significant therein. She specifically asked him if he was hearing voices telling him to hurt himself or hurt or kill other people, and he said, "No." Again, the second PAO evaluated the voices for command content and found none.

The second PAO consulted by telephone with the on-call psychiatrist, relating that the voices had lifted and that the patient was quiet and co-operative. The psychiatrist confirmed that he was familiar with the patient from the previous in-patient hospitalizations. The psychiatrist discussed the medication he wanted for the patient to take after discharge.

The Hospital believes that the hallucinations were adequately probed. The patient's hallucinations had been evaluated by two PAO's -- both of them master's degree prepared social workers with over five year's experience in psychiatric assessment. They questioned the patient repeatedly on lethality and command

First, the Hospital understands that the medication prescribed and the dose were proper. No adverse reaction or interaction have been alleged. The clinical picture on discharge was consistent with a therapeutic response to the medication.

Second, the PAO's and emergency department physician in Mr. Goldstein's case all understood that if they believed that a psychiatrist's on-site evaluation were required or if they disagreed with the plan or disposition, the psychiatrist would have come in. Also, if a psychiatrist's personal examination of a patient were needed, the patient could have been designated "ED observe," that is, held in the emergency department overnight to be seen by the on-call psychiatrist on morning rounds.

The Commission's report concludes that it is extremely rare for a psychiatrist to come in to the hospital for an examination "off" hours. The evidence gathered by the CQC investigator is again anecdotal -- since the Hospital has no data on such visits in a collectible form. However, if such visits are not frequent, the Hospital believes that it is due to its "ED observe" policy.

If PAO's or on-call psychiatrist or the emergency department physician are uncertain about whether a patient should be discharged, that patient can be, and often is, held in the Emergency Department until the on-call psychiatrist comes in for morning rounds. One of the duties of the on-call psychiatrist is to round psychiatric patients in the emergency department the following morning.

The first recommendation is that OMH require facilities to promulgate policies specifying circumstances under which psychiatrists conduct in-person examinations of emergency department patients prior to discharge.

The Hospital would respectfully suggest that if the OMH considers adoption of such a standard, specific study would be appropriate about whether such a system is superior to the present one of relying on clinical competence of the individual practitioners, since such a standard would substitute protocol formulated without reference to particular patients for the clinical judgment of the evaluators and it might well increase the cost of mental health care significantly without necessarily improving outcomes.

In the context of Mr. Goldstein's case, the Hospital would point out that there is no evidence that such an examination would have changed the outcome for the patient. The Hospital's otherwise excellent experience with the present system of relying on clinical judgment suggests that the present system is appropriate. Likewise, the draft report's acknowledgement of the fundamental role of clinical judgment also cautions against precipitous change in the present system.

Recommendation (2):

The second recommendation is that hospitals consider establishing holding/observation beds. The Hospital understands that this recommendation would best be directed to the OMH for

No one can turn back the clock to Sunday, October 7, 1991, to change the course of events that took place on that day. Nor can anyone assume that the judicial system will determine that Mr. Goldstein is responsible for the deaths of the two individuals or that the murders were related to his psychiatric condition. As the Commission acknowledges, no one can determine whether the patient's responses would have been different if the suggestions of the Commission had been employed in his care and treatment.

Nevertheless, for the Commission to report completely and accurately on Mrs. Goldstein's care, the Hospital does believe that certain salient facts should be included in its report.

The Hospital is pleased that the Commission found no violation of any existing rules and procedures governing the treatment of mentally ill patients in its emergency department.

In considering changes in the regulations and procedures governing care of mentally ill, the Hospital respectfully requests that the Commission consider that the OMH, the Hospital and facilities and practitioners throughout the community have worked hard to design their systems and render care and treatment to patients like Mr. Goldstein in order to minimize the likelihood of violence. Changes to policies should not be made on the basis of one case of presumably tragic outcome, but upon careful study and reflection.

A:\response.gen

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-381-7098.

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/TTY)



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