

# In the Matter of David Dix



**A Report by the New York State  
Commission on Quality of Care  
for the Mentally Disabled  
and  
The Mental Hygiene  
Medical Review Board**

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## EXECUTIVE SUMMARY

On January 3, 1999, David Dix [a pseudonym] is alleged to have pushed a young woman to her death in front of an oncoming subway train in New York City. Following this tragic incident, the Commission and its Mental Hygiene Medical Review Board conducted an investigation to determine what mental health services Mr. Dix had received, to assess whether the services were adequate and appropriate, and whether they represented a cost-effective expenditure of public funds. This investigation concluded with recommendations for improving the care of individuals who are seriously and persistently mentally ill, whose histories include behaviors dangerous to themselves or others and who are uncooperative with outpatient mental health services.

David Dix began receiving mental health services as a young adult and, as he aged, frequently evidenced hallucinations, delusions and spontaneous, unprovoked acts of aggression when not taking psychoactive medication. He consistently failed to take prescribed medication after discharge unless he was in a supervised setting. Despite an awareness over the years by several mental health care providers that Mr. Dix required a supervised living situation and close monitoring of his psychiatric symptoms and medication compliance, and despite his mother's pleas that he be discharged to a supervised setting, he was repeatedly discharged to live in an apartment with periodic therapy and medication management from a clinic—an arrangement that never successfully kept Mr. Dix from decompensating.

By the time he was 27, Mr. Dix had twice been admitted to a psychiatric center and had lived in a State-operated community residence and in an adult home. His nearly four-year stay in the community residence and adult home, during which time he required no hospitalization and where he received on-site services, including critical medication monitoring, represented the last period of stability in his life, prior to the January 1999 incident. (Pages 1-4)

The two year period after Mr. Dix left the adult home to live in an apartment in 1997 was marked by frequent visits to emergency rooms and numerous inpatient admissions, sometimes precipitated by his own requests for treatment and at other times by his aggressive behavior towards others. His treatment sources were multiple, the care uncoordinated, costly, and, according to the Commission's Medical Review Board, often inappropriate in its failure to recognize his need for intensive, daily contact. Mr. Dix received 199 days of inpatient and emergency room services, on 15 different occasions, in six different hospitals from 1997 to 1999. Four different clinics provided outpatient services in this time period. In 1998 alone, mental health services for Mr. Dix cost over \$88,000. (Pages 4-10)

In an effort to address the fragmented and oftentimes inappropriate care afforded Mr. Dix and identify available alternatives that have proven more effective and less costly, the Commission's report concludes with the recommendation that the Office of Mental Health conduct a comprehensive assessment of current housing resources—including, but not limited to, state and voluntary community residences and supported living programs—and the current availability of Intensive Case Managers and Assertive Community Treatment teams to determine the need for additional residential and community support services for individuals whose serious and persistent mental illness has represented a danger to themselves or others or has resulted in frequent rehospitalizations.

Other recommendations to State agencies include:

- The Office of Mental Health, in collaboration with the Department of Health, should review the feasibility of affording hospitals access to the Medicaid Management Information Service, to enable hospitals to track previous providers of service for an individual. This review should include necessary safeguards to prevent the inappropriate use or disclosure of such information.
- The Office of Mental Health, together with the Department of Health and Division of the Budget, should examine means to utilize resources more efficiently and effectively to support the development of community services and decrease the repeated utilization of costly ER and inpatient hospitalizations by persons such as Mr. Dix.
- The Office of Mental Health in its revision of the incident reporting regulations, should ensure that patient assaults on staff and other patients are classified as incidents and investigated and managed as such, including reporting to OMH for monitoring purposes.
- The Office of Mental Health should alert all hospitals with psychiatric units to the provisions of State law governing the role of family members and other significant persons in the treatment and discharge planning process and ensure that these individuals are afforded a meaningful role in such decisions.
- The Office of Mental Health should encourage the use of objective aggression scales to assess potential dangerousness, as well as securing detailed histories from other providers and family members; and
- The Office of Mental Health should promote the training of physicians with regard to new and promising anti-psychotic medications and the benefits of such medications in dealing with patients who have a history of non-compliance with more traditional medications. Likewise, the Commission and the Medical Review Board recommended that clinicians educate patients about the intended effects of medications and the management of side effects.

The Commission and Medical Review Board also recommended that all facilities discharging individuals with serious mental illness and a history of non-compliance with aftercare ensure, through training and supervision, that staff who prepare discharge plans are aware of and consider the full array of services in the community which may be needed to support the individual. Additionally, case managers should be assigned and held responsible for monitoring compliance with clinical recommendations and prompting additional interventions as they become necessary. (Pages 11-15)

The response of the Office of Mental Health is appended to the report.

## INTRODUCTION

On January 3, 1999, 29 year-old David Dix<sup>1</sup> allegedly pushed a young woman in front of an oncoming subway train in New York City, causing her death.

Mr. Dix was seriously, persistently and, at times, dangerously mentally ill and had often sought out services from New York State's public mental health system. During the one year span immediately prior to January 3, 1999, Mr. Dix received inpatient or emergency room psychiatric treatment at four hospitals on eight separate occasions at a cost of over \$87,000. His last inpatient admission had ended just two weeks prior to January 3, 1999.

The Commission and its Mental Hygiene Medical Review Board<sup>2</sup> conducted a review of Mr. Dix's mental health treatment. As indicated in the findings, Mr. Dix would often present himself for treatment — complaining that he was anxious, hearing voices and unable to control himself — and ask to be helped, at times requesting supervised housing. His treatment history also reveals several other consistent characteristics:

- failure to take prescribed psychoactive medication after discharge unless he was in a supervised setting;
- unwillingness to accept long-acting psychoactive medication via intramuscular injection (with two short-lived exceptions);
- spontaneous, unprovoked acts of aggression, mostly directed at women, over which Mr. Dix said he had no control;
- hallucinations and delusions which cleared with anti-psychotic medication;
- consistent requests from his mother that he be discharged to a supervised setting;
- varying rates of attendance at outpatient services, except when in an adult home where services were provided on-site; and
- awareness by several mental health care providers over the years that Mr. Dix required a supervised living situation and close monitoring of his psychiatric symptoms and medication compliance.

The conclusions and recommendations of the Commission and Medical Review Board address the questions of how best to treat and support individuals who, like Mr. Dix, are seriously and persistently mentally ill and have a propensity towards violence when not receiving adequate treatment.

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<sup>1</sup> Pseudonym

<sup>2</sup> The Mental Hygiene Medical Review Board is a panel of physicians, with expertise in the fields of psychiatry, forensic pathology, surgery and internal medicine, appointed by the Governor to assist the Commission in its activities.

## **FINDINGS: A BRIEF MENTAL HEALTH HISTORY**

### **THE EARLY YEARS**

David Dix was a gifted student who excelled in elementary school and graduated from a special science program in the Bronx. He went on to study for a year at the State University at Stony Brook, majoring in psychology. In December of his freshman year, he began to show symptoms of mental illness; he reported hearing voices and was acting uncharacteristically. The private psychiatrist treating Mr. Dix prescribed medication to treat his symptoms. This marked the beginning of Mr. Dix's treatment which would lead him through multiple hospitals and community-based programs in New York City.

### **CREEDMOOR PSYCHIATRIC CENTER 8/11/89 - 9/14/89**

Mr. Dix's first psychiatric admission occurred in the summer of 1989 after his mother summoned the police for assistance. Mr. Dix's behavior had become increasingly more bizarre and included auditory hallucinations and paranoid delusions. His mother reported that Mr. Dix was non-compliant with anti-psychotic medication which precipitated his decompensation. During the admission examination, he threatened the physician. He also reported delusions that he had psychic powers and was growing extra body parts.

Creedmoor physicians initially diagnosed Mr. Dix as paranoid schizophrenic, with the intent to rule out an affective disorder with psychotic features. Mr. Dix would carry the diagnosis of schizophrenia with him throughout his adult life and would be treated with anti-psychotic medication, both as an inpatient and on an outpatient basis.

Mr. Dix responded to medication at Creedmoor and within two weeks he denied hearing voices. Home visits went well, and Mr. Dix was discharged in September 1989 with medication. Arrangements were made for outpatient treatment at the Clearview Clinic. He returned to live with his mother.

### **CLEARVIEW CLINIC 9/20/89 - 5/22/92**

Mr. Dix was seen at the Clearview Clinic and was offered standard outpatient treatment or day hospital placement, a more intensive treatment option. He refused the latter. He was subsequently seen in clinic sessions, which initially occurred without interruption, but eventually became marked by failed appointments and non-compliance with his medication.

### **CREEDMOOR PSYCHIATRIC CENTER 8/29/92 - 9/9/92**

Three years after his initial hospitalization at Creedmoor, Mr. Dix was brought to Queens Hospital by the New York City Police Department (NYPD) after he threatened his family. Mr. Dix reported that he had stopped taking all medications five weeks earlier. He was tearful, bizarre, and had delusions that he was shrinking. Mr. Dix was transferred to Creedmoor as an emergency admission. He was stabilized on medication and within 10 days returned home to reside with his mother.

### **CREEDMOOR PSYCHIATRIC CENTER'S CRISIS RESIDENCE 12/6/92 - 12/14/92**

Mr. Dix appeared at the Creedmoor Crisis Residence in December 1992, reporting that he had been non-compliant with medication for the past three weeks. He advised staff that he had been residing with a roommate in the fall and early winter, but presently had no place to live. By this time, Mr. Dix's mother had determined his living with her was not a good situation for either of them.

While at the Crisis Residence, Mr. Dix denied hearing voices, although he appeared to be preoccupied and responding to internal stimuli. His stay ended in a seriously assaultive incident. Shortly after midnight on December 14, he unexpectedly became agitated and paranoid, believing someone was after him with a gun and demanding to leave the residence. He began to follow a female staff member and eventually

barricaded himself in the nursing station. A physician was summoned, and Mr. Dix was medicated. A short time later, Mr. Dix approached the physician and asked whether he had given him poison. This questioning was followed by a period of increasing agitation which culminated in Mr. Dix assaulting three female staff members with his fists. Security was contacted, and Mr. Dix was restrained and taken immediately to Creedmoor's Secure Care Unit.

#### **CREEDMOOR PSYCHIATRIC CENTER 12/14/92 - 8/25/93**

On admission to the Secure Unit, Mr. Dix was exceptionally agitated and threatening. He frequently accused staff of administering cyanide to him. In therapy he stated that he did not know why he hit people. He promised not to be assaultive again. But the assaultive behavior continued, and he hit another staff member several days later. In subsequent weeks, clinicians recommended that Mr. Dix accept Haldol Decanoate (long-acting intramuscular injection). Mr. Dix refused. Several changes were made to Mr. Dix's medication during March, April and May of 1993, and by May, Mr. Dix appeared to be doing well. Day and weekend visits to his mother were uneventful (although it was later learned that Mr. Dix did not take his medication while on home visits). Consequently, Mr. Dix was transferred to Creedmoor's apartment program. He remained there for three months until August 25, when he was placed at Creedmoor's State Operated Community Residence (SOCR) and simultaneously admitted to the Creedmoor-operated Queens Village Day Treatment Program (QVDTP).

#### **CREEDMOOR'S SOCR AND QVDTP 8/25/93 - 11/9/94**

While in the residence and at day treatment, Mr. Dix appeared to perform well. By July 1994 efforts were made to search for other treatment-oriented residential options for Mr. Dix, such as supportive apartments. During his interview with staff of a voluntary-operated residential program, Mr. Dix reportedly answered questions evasively and said his goal was to live with his mother and to stop taking medication. Documentation of the interview indicates that "when he was asked about the incident where he assaulted three staff, he brushed it off as if it was nothing." In view of his answers to the questions posed and his lack of appreciation for the seriousness of his assaultive behavior, Creedmoor staff decided to refer Mr. Dix for placement in an Adult Home "as he has failed his interviews at supportive apartments."

This plan was discussed with Mr. Dix's mother, who was agreeable, noting that David "needs 24 hour supervision, needs someone to give him his medication." On November 10, 1994, Mr. Dix accepted placement at the Leben Adult Home. His outpatient treatment was to be provided on-site by the New York Psychotherapy and Counseling Center (NYPCC).

#### **LEBEN HOME / NEW YORK PSYCHOTHERAPY AND COUNSELING CENTER**

Mr. Dix stayed at the Leben Home from November 1994 to September 1996. Occasional notes from October 1995 to July 1996 state that he was waiting for supportive housing, but this never materialized. During that time he received assistance in taking medication as well as weekly counseling sessions and monthly medication monitoring by a psychiatrist, provided by NYPCC, which had an on-site mental health team. Mr. Dix's mental health treatment plans were updated each quarter, addressing his medication compliance, lack of insight into his limitations, and his relationships with family members.

In the fall of 1996, Mr. Dix left Leben briefly to live with a roommate. On December 6, 1996, he was picked up by police at a supermarket, after he got into an argument with someone, and was taken to Jamaica Hospital. He claimed that he did not know what happened, accepted voluntary admission, and was treated with anti-psychotic medication; his symptoms cleared and he was discharged on December 23, 1996 to his apartment with arrangements for outpatient clinic treatment—a treatment, response and discharge pattern that would become increasingly common. In this instance, Mr. Dix was discharged with an outpatient appointment at the Jamaica Hospital Mental Health Clinic.

Mr. Dix stayed in an apartment until January 1997 when he returned to the Leben Home for approximately five months. During his stay at the adult home from January to May, he continued to receive clinical services from NYPCC. According to Medicaid billing records, he also received on-site services from staff affiliated with the Staten Island University Hospital for a “developmental delay” and “learning difficulties”. Since the Staten Island Hospital has been unable to produce any clinical records, the Commission is unable to explain why services (costing nearly twice as much as NYPCC’s weekly clinic visits) were provided to a young man with no history of a learning disability.<sup>3</sup>

On March 27, 1997 Mr. Dix took himself to the Elmhurst Hospital ER asking for treatment. He reported that he had been feeling anxious and nervous for the previous three months and requested to go back to Creedmoor where he had a “good doctor”. Elmhurst’s evaluation found that he was mildly anxious, but had no thought disorder. His medication regimen was assessed to be appropriate, and so he was discharged. He returned to the Leben Home, only to leave within a few months.

## **LAST TWO YEARS OF TREATMENT**

The two-year period from early 1997 to January of 1999 was marked by frequent visits to ERs and CPEPs (specialized psychiatric emergency rooms) and frequent inpatient admissions for Mr. Dix, as he repeatedly sought help for his hallucinations and delusions. It was a period when stability and contentment were increasingly elusive.

### **INTERFAITH MEDICAL CENTER 5/6/97 - 5/30/97**

Within a day or two of leaving the Leben Adult Home, Mr. Dix was brought by EMS to Interfaith Medical Center, complaining that he was nervous and scared and was hearing voices calling his name. He was admitted on voluntary status and started on anti-psychotic medication. Recognizing that Mr. Dix would do much better in a supervised living arrangement, social workers arranged for him to go on pass to visit two adult homes. The discharge summary reports that he refused placement in either home and, instead, would live in his own apartment in Queens. He was to receive outpatient services at Brooklyn Jewish Mental Health Clinic (a division of Interfaith) with an appointment set for June 5, 1997. According to the outpatient records, Mr. Dix kept that appointment and attended the clinic between five to eight additional times between June and September 1997.<sup>4</sup>

### **BELLEVUE MEDICAL CENTER HOSPITAL 9/11/97 - 9/13/97**

Three and one-half months passed and Mr. Dix again needed intensive psychiatric services. He spent two days in an observation bed at Bellevue Medical Center Hospital after he came there asking for more medication to treat persistent auditory and visual hallucinations. He stated that he wanted to be in the hospital and asked to be sent back to Creedmoor. Clinicians called the community residence at Creedmoor where Mr. Dix had lived earlier and were told that the state-operated community residence could only accept admissions directly from Creedmoor Psychiatric Center. Clinicians also called the Leben Home and were told that Mr. Dix would not be welcome to return. The hospital records document conversations with Mr. Dix’s mother in which she related her son’s extensive history of psychiatric treatment, his pattern of

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<sup>3</sup> On September 22, 1999, the New York State Attorney General announced that Staten Island University Hospital has agreed to pay \$45 million to settle a state Medicaid overbilling case. The case alleges that SIUH billed Medicaid for visits occurring in more than 500 part-time “clinics” that were actually only rooms of clients living in adult homes or group residences. Additionally, the Attorney General found that services were allegedly unsupported by evidence of medical necessity and included more recreational activities than therapy.

<sup>4</sup> Billing and clinical records are not consistent concerning the number of visits.

non-compliance with medication as soon as he is discharged, and her request for a supportive living arrangement for him—to break the cycle of repeated admissions.

Mr. Dix was discharged from Bellevue back to his apartment with a two weeks supply of anti-psychotic medication and a referral (not an appointment) to Brooklyn Jewish Mental Health Clinic. Staff left a voice message on the clinic line advising clinic staff to expect a call from Mr. Dix. On September 15 and 17, Mr. Dix was treated at the clinic, but by September 18 required inpatient admission.

#### **JAMAICA HOSPITAL 9/18/97 - 9/26/97**

On September 18, 1997, EMS brought Mr. Dix to Jamaica Hospital at his own request. Records indicate that Mr. Dix had gone into Manhattan from Queens to buy music and had difficulty finding his way home. When he made it home, he called 911 and reported his need to go to the hospital. On admission, he denied suicidal and homicidal ideation, but stated, “I cannot cope or function alone.” He was treated for eight days and then discharged to his apartment on Depakote and Haldol, the same anti-psychotic medication which had been prescribed consistently for him. An outpatient appointment at Jamaica Hospital was scheduled for October 1.

#### **JAMAICA HOSPITAL 11/14/97**

Within seven weeks of his last inpatient admission, Mr. Dix was again taken to the Jamaica Hospital ER after he attacked a female doctor with no warning while he was waiting for his appointment at the Mental Health Clinic. When questioned about the attack, Mr. Dix responded that he did not know why he did it. He was placed in restraints and medicated. Because Jamaica Hospital had no beds, he was transferred to North General Hospital. Jamaica Hospital clinicians recommended that, upon discharge, Mr. Dix should go to a day treatment program where he could be monitored more closely.

#### **NORTH GENERAL HOSPITAL 11/14/97 - 11/26/97**

When Mr. Dix was admitted on a voluntary status, the hospital called his mother who again explained about her son’s non-compliance and need for supervised housing. He was treated with Haldol and Depakote, medications that had been helpful in the past. He was discharged back to his apartment because “patient left [supervised] residence to live in the community,” apparently referring to his leaving the Leben Home months earlier. His first outpatient appointment, which he kept, was for two days after his discharge at the Jamaica Hospital Mental Health Clinic. During the visit, Mr. Dix was informed that he could no longer attend the clinic, due to the assault incident of 11/14, and that he would be referred to a day program which would provide closer monitoring. This plan, however, never materialized.

#### **ELMHURST HOSPITAL 12/15/97 - 1/2/98**

Less than a month elapsed before Mr. Dix again needed inpatient treatment. In mid-December, Mr. Dix was brought to Elmhurst Hospital by NYPD in response to his pushing a woman to the floor in a bookstore. An initial evaluation found that Mr. Dix had become troubled with poor sleep and auditory hallucinations and, again, was requesting hospitalization. He informed clinicians that he felt that someone else was taking him over and that this made him angry and caused him to attack women. In his own words, “I cannot control myself.” Within three days of his admission, Mr. Dix, without provocation, attempted to attack a female resident physician, obeying the voices telling him to do so. He was placed in seclusion and medicated. Later he claimed he did not remember the attempted attack.

On Christmas Eve, Mr. Dix informed staff that one of his friends was a master psychic who was telling him strange things from far away, telling him that he was never born, that he was a ghost, and that people would come to get him. He said he knew he could not function independently in the community, and he



requested placement. Further interviews revealed that Mr. Dix believed something or somebody entered his body which caused him to push people against his will.

A December 31 note by a resident physician indicated that Mr. Dix was willing to go to an adult home and a referral packet had been submitted. It also noted that “patient can be discharged early if he is willing to go back to his own apartment.” Mr. Dix was discharged to his residence shortly after New Year’s Day, 1998. At discharge, Mr. Dix was medicated with the anti-psychotic medication traditionally used to treat him. He refused the recommendation of Haldol Decanoate. It does not appear that Mr. Dix was given an appointment for outpatient care following discharge; nor do billing records indicate he attended any outpatient programs in the weeks that followed.

#### **NORTH GENERAL HOSPITAL 2/17/98 - 3/5/98**

Six weeks after his New Year’s discharge, Mr. Dix was brought by ambulance to Jamaica Hospital. After he had kicked down his roommate’s door, he told his roommate that he was having a psychotic break and asked the roommate to call the police. He was taken to Jamaica Hospital, was medicated, and the next day he was transferred to North General Hospital for admission. Admission notes at North General state that Mr. Dix “admits hearing voices but could not elaborate.” “Has history of repeated, unprovoked attacks. He claims he usually has a sudden rage with the urge to attack without provocation.”

After an approximately two week stay, Mr. Dix was discharged to his apartment, with medications and an appointment in the following week for outpatient treatment at the Interfaith Hospital Mental Health Clinic. Mr. Dix did not keep this appointment, according to billing records.

#### **BELLEVUE CPEP 4/5/98 - 4/8/98**

A month later, Mr. Dix walked into the Comprehensive Psychiatric Emergency Room (CPEP) at Bellevue Hospital and asked to discuss the mental health issues of a friend of his at Creedmoor Psychiatric Center. He then reported that he (Mr. Dix) was getting only four hours of sleep a night and admitted to having had auditory hallucinations a week earlier. He was viewed as exhibiting manic symptoms, and was treated with anti-psychotic medication.

While in the CPEP, Mr. Dix was approached about participating in a drug research protocol. On April 7, 1998, he agreed to participate in research to examine “the clinical effects of cross-titration of anti-psychotics with Ziprasidone.” No further mention of this is made, and there is no evidence that Mr. Dix actually became a participant in the drug study.

Outpatient services were arranged for Mr. Dix at Long Island Jewish Hospital (LIJ), in accordance with his preferences, for the following week, with back-up services at Jamaica Hospital which was closer. Billing records indicate that Mr. Dix kept one LIJ Hospital clinic appointment on April 13 and then received outpatient services at Jamaica Hospital on April 17. The record documents no medications given to Mr. Dix while in the Bellevue CPEP on April 8, and none given to him when he was discharged.

#### **JAMAICA HOSPITAL 5/2/98 - 6/11/98**

Less than a month after his discharge from the Bellevue CPEP, Mr. Dix was voluntarily admitted to Jamaica Hospital following his assault of two people at a fast-food restaurant. Mr. Dix was not able to explain why he attacked the other patrons, and said that he did not remember what happened. On admission, he expressed the delusion that three people were manipulating his thoughts, that one of the three was putting him into a trance. He also admitted to auditory hallucinations, but denied homicidal/suicidal ideation.

Two days into his admission, Mr. Dix punched a female patient. He was placed on constant observation. By day four of his hospitalization, the hospital records report that he was beginning to clear and believed that he could control himself. In therapy sessions, however, he was still unable to enter into a contract promising to seek help from staff if he felt the urge to hurt himself or others, since he did not

know why he attacked the other patient and the restaurant patrons. Consequently, he was kept on constant observation until May 11. A physician's note on May 12 shows Mr. Dix improving, denying auditory and visual hallucinations. Ten days later, on May 22, 1998, Mr. Dix was discharged. The social worker's discharge note reports an unusual discharge arrangement, perhaps because there was information to believe his former residence was no longer available: Mr. Dix was to be transported home in an ambulette, accompanied by a hospital security officer and a member of the nursing staff. However, he was readmitted the same day when it was discovered that his rented room was "uninhabitable" (no electricity, non-functioning bathroom, vermin infestation and other problems),

The plan was for Mr. Dix to stay in the hospital until suitable housing was found. On June 3 and 10, he was granted escorted passes to secure housing, and on June 11 he was discharged. His discharge medications were Haldol, the same anti-psychotic medication used during each of his inpatient stays, and Depakote. He was given an outpatient appointment for June 19 at Hillside Hospital (a division of Long Island Jewish Hospital.) He did not keep the appointment.

### **BROOKDALE HOSPITAL 6/20/98 - 7/31/98**

During this admission to Brookdale Hospital the frequency between attacks shrunk to days. On June 20, Mr. Dix was brought to Brookdale University Hospital by EMS for punching a female on a subway. Mr. Dix reported to clinicians that he had been discharged from Jamaica Hospital about two weeks ago, and since then had been having bizarre experiences of seeing people turn purple and himself shrinking. Reminiscent of earlier conversations, he stated that he could not explain the attack, other than to say that sometimes he could not control his arms, and that's when he got into trouble. The unprovoked aggression continued, and during Mr. Dix's admission physical he assaulted his physician.

Two days into his admission, Mr. Dix spoke again of his assault on the female in the subway. He informed clinicians that he had slapped and punched the woman, but he didn't know why. He said that he felt better after the assault. Mr. Dix's physician's notes comment on Mr. Dix's indifference to the consequences of the impulsive assaultive behavior.

On June 23, while preparing for a group therapy session, Mr. Dix jumped to his feet and attacked the physician running the session. He struck the physician in the face with both hands. As staff intervened, Mr. Dix struck out at them on two occasions before he could be controlled.

In response to these serious, unprovoked incidents of aggression, and Mr. Dix's overall treatment needs, Brookdale clinicians made the decision to transfer Mr. Dix to Creedmoor Psychiatric Center, a plan to which Mr. Dix was ultimately agreeable. According to the Brookdale record, Creedmoor responded that there would be a three week wait for admission. A need for additional medical testing at Brookdale may have delayed the transfer and lengthened the wait. In an interview with Commission staff, the Director of Creedmoor revealed that admission screening staff quickly recognized Mr. Dix and determined that they would admit him as soon as a bed became available.

By the end of June and through early July, Mr. Dix acknowledged to Brookdale clinicians that he was hearing voices telling him not to go to L.A. and be in the movies. He spoke to his mother who refused to accept him home in view of his non-compliance with outpatient treatment. Initially, Mr. Dix requested to be released to his own apartment, but then decided to accept placement in a long-term structured setting. Around the Fourth of July, Mr. Dix told his physician, "Hey! I feel fine. Don't worry, I'm not going to hurt anyone." But, within a few days, he suddenly and without any provocation, lunged at a female aide, punching her between the eyes. Male aides interceded and Mr. Dix also struck them as they attempted to restrain him. After Mr. Dix was controlled, he expressed to staff, in a flat affect, "It happened again."

For most of the remainder of July, Mr. Dix remained in his room preferring to be alone, as it allowed him to "feel safer and not like he was going to hurt someone". By July 15, after receiving information on Mr. Dix's most recent assault, Creedmoor staff advised Brookdale that they would accept Mr. Dix as soon

as a bed became available. Therapy sessions through July found that Mr. Dix “...senses panic and, within 15 seconds, will strike out... he feels controlled, like a puppet on a string...” According to clinical records, he remained reclusive, restless and preoccupied with his inner thoughts.

On July 28, 1998 Mr. Dix presented a letter to his physician requesting discharge from the hospital. Since Mr. Dix was on voluntary status, Mental Hygiene Law requires that the hospital either release him, or within 72 hours apply to the court for an order authorizing his retention on an involuntary status. Second opinions from two psychiatrists were obtained relative to Mr. Dix’s mental status and potential for violence, and the decision was reached to comply with the discharge request. In preparation for discharge to the apartment he occupied prior to admission, Mr. Dix was administered long-acting Haldol Decanoate on both July 29 and July 30, in addition to the oral Haldol he was prescribed. He was discharged on July 31 with an appointment for outpatient services the following day at Long Island Jewish Hospital.

Mr. Dix did not keep the outpatient appointment. However, on August 12, he presented at the Long Island Jewish Hospital complaining of rigidity, sleeplessness, decreased urination, dry mouth and decreased appetite—side effects of the Haldol. He was seen by a physician who assessed his symptoms and suggested that if the impaired urination continued, the oral Haldol be decreased until the Haldol Decanoate wore off. Mr. Dix returned to the clinic on August 17. The entry for that clinic visit is difficult to interpret, in light of the information above. Mr. Dix was reportedly offered Haldol Decanoate (there was no mention of the double administration on July 29 and 30 and no mention of the problem with side-effects evident on the 12<sup>th</sup>). When he refused, he was given a script for a ten day supply of Haldol, an appointment for ten days hence, and a list of clinics in the Queens and Nassau area, which were more convenient to him. Mr. Dix did not return to the clinic.

On August 11, Creedmoor sent Brookdale a signed order of transfer dated for August 14 only to learn that Mr. Dix had been discharged without Creedmoor’s knowledge.

#### **BLEULER PSYCHOTHERAPY CENTER 9/18/98 - 11/18/98**

On September 18 Mr. Dix made contact with the Bleuler Center requesting outpatient treatment. Mr. Dix was seen on two occasions (9/22 and 11/11), and he failed to appear for other scheduled appointments (11/7 and 11/18). Subsequently, Bleuler became aware that Mr. Dix had been hospitalized at North General Hospital.

#### **BELLEVUE HOSPITAL CPEP 11/7/98 - 11/8/98**

In early November, Mr. Dix appeared again at the CPEP with vague complaints of not feeling well and insomnia. He reportedly had no suicidal or aggressive ideation, no hallucinations, and was described as a patient who “understood the nature of his illness and follows recommendations.” The record notes that his doctor and mother were notified of his appearance at the CPEP. (It is unclear which doctor was notified, as this person and his/her affiliation were not identified, and Mr. Dix mentioned a doctor at the Bleuler Clinic and one at Long Island Jewish Hospital). There was no documentation of Mr. Dix having been given medication at discharge.

#### **JAMAICA HOSPITAL 11/20/98 - 11/24/98**

Not quite two weeks later, Mr. Dix walked into the Jamaica Hospital ER complaining that he was unable to concentrate, and that he believed someone was forcing him to do things. He advised clinicians that he was hearing voices of someone inhabiting him, telling him his brain had been taken out. This entity (presumably the one he believed was inhabiting him and whose voice he heard) had been pushing him or beating him up over the past two weeks, he explained. According to the hospital record, this experience caused him to want to push or beat others.

Mr. Dix's symptoms, including feelings of paranoia, continued over the next few days as he was held and monitored in the ER. He was observed responding to internal stimuli and to laugh inappropriately. On November 22, Mr. Dix was observed talking to the television set and having difficulty responding to limit-setting. The next day he requested to be sent to the inpatient service, expressing the hope that going there would help him deal with his feelings that something was wrong. During further sessions, his physician documented that Mr. Dix required admission but was awaiting a bed. The physician's note also included the direction, "do not refer to J[amaica] H[ospital] Mental Health Clinic as patient attacked a psychiatrist there." On November 24, Mr. Dix was transferred to North General Hospital. Mr. Dix's medication on transfer was Haldol.

#### **NORTH GENERAL HOSPITAL 11/24/98 - 12/15/98**

On admission to North General, Mr. Dix continued to speak of being inhabited by an unknown entity. He reported, "They removed my brain, I don't know why. I am hearing voices telling me something will happen and people will become psychotic." Because he couldn't see who these people were, he requested eyeglasses so he could find the faces of the voices. Haldol was prescribed to treat the psychosis.

On the first of December, North General staff made contact with Mr. Dix's mother. She advised treatment staff of Mr. Dix's history of non-compliance with outpatient treatment and his need for a supervised residential program. Clinically, Mr. Dix was showing some signs of improvement but was still "severely thought disordered." On December 4, Mr. Dix remained "floridly psychotic", but signs of some improvement were noted. By December 7, he said that he felt like someone was inside him who wanted him to do something. The next day, he denied hearing voices, but he remained unkempt and unwashed.

On December 10, clinicians held a meeting with Mr. Dix and his mother, who was concerned over her son's discharge plan. At that meeting Mr. Dix agreed to accept a supervised residential program and a housing referral application was completed. According to the record, "another application for a ICM worker will be in place." [There is no indication in the record that a first application for an Intensive Case Manager was made, by whom, or when.] It was recommended that Mr. Dix accept Haldol Decanoate, but he refused.

On December 15 Mr. Dix was assessed as improved, but still exhibiting signs of schizophrenia. He was released to his apartment with a referral for structured residential placement. Aftercare was to be provided by the Bleuler Clinic, with the first appointment set for the next day. His medication on discharge was Haldol in tablet form.

#### **LAST KNOWN CLINICAL CONTACT: BLEULER CLINIC 12/16/98**

Mr. Dix kept his appointment at the Bleuler Clinic on December 16. He advised clinicians there that he was discharged from North General with only a one-week supply of medication. A follow-up appointment with Bleuler's psychiatrist was scheduled for December 22, so that the psychiatrist could prescribe medication for Mr. Dix. He did not appear for the appointment with the psychiatrist or for his scheduled December 23 appointment with his therapist. Attempts were made to contact Mr. Dix without success and, on December 26, a letter was sent to his last known residence advising him to re-contact the clinic by January 6, 1999 or his case would be closed. Before this could happen, Mr. Dix allegedly pushed a woman into the path of a subway train and she was killed. He made no attempt to flee and was arrested.

## 1997-1999: TWO YEARS OF INTENSE USE OF MENTAL HEALTH SERVICES AFTER LEAVING LEBEN HOME

### OUTPATIENT SERVICES

### INPATIENT SERVICES

	Interfaith Medical Center 5/97 (25 days)
Brooklyn Jewish M.H. Clinic 6/97-9/97 (6 to 9 visits)	
	Bellevue Med. Center Hosp. CPEP 9/97 (2 days)
	Jamaica Hosp. 9/97 (8 days)
Jamaica Hosp. M.H. Clinic 10/97 (5 visits)	Jamaica ER 10/97-11/97 (2 visits)
	North General Hosp. 11/97 (13 days)
Jamaica Hosp. M.H. Clinic 11/97 (1 visit)	
	Elmhurst Hosp. 12/97 (18 days)
	Jamaica ER (1 visit) 2/98
	North General Hosp. 2/98 (16 days)
	Bellevue Med. Center Hosp. CPEP 4/98 (4 days)
Long Island Jewish M.H. Clinic 4/98 (1 visit)	
Jamaica Hosp. M.H. Clinic 4/98 (1 visit)	
	Jamaica Hosp. 5/98 (41 days)
	Brookdale Hosp. 6/98 (42 days)
Long Island Jewish M.H. Clinic 8/98 (2 visits)	
Bleuler Clinic 9/98-11/98 (3 visits)	
	Bellevue Med. Center Hosp. CPEP 11/98 (2 days)
	Jamaica Hosp. ER 11/98 (4 days)
	North General Hosp. 11/98 (21 days)
Bleuler Clinic 12/98 (1 visit)	

## CONCLUSIONS AND RECOMMENDATIONS

As indicated in the foregoing, Mr. Dix was a young, bright, but seriously mentally ill man. Although he often recognized his need for treatment when experiencing acute exacerbations of his illness, once stabilized on medications and released from hospitals, he would not, on his own, continue on a course of treatment to sustain his well-being. He would decompensate, often injuring people during such states.

In the less than two years after leaving a supervised residential setting with on-site mental health services, he was hospitalized eight times at five different hospitals and was treated in hospitals' psychiatric emergency rooms on at least seven occasions. When referred to outpatient clinics for regular care, he would either not attend or attend only sporadically. This fragmented series of services was insufficient to meet the complex needs of Mr. Dix and to protect those around him. It has been the Commission's experience that the problematic issues reflected in the David Dix case are not uncommon.

In the opinion of the Commission and members of its Medical Review Board (MRB), several conclusions can be drawn from the investigation of Mr. Dix's care and treatment, leading to recommendations. The underpinning of these conclusions and recommendations is the need to provide a coordinated network of services, sufficient to ensure appropriate treatment and supervision for seriously and persistently mentally ill people with histories of violence, one in which protection for both the individual and the community is a priority, in keeping with the mission of the public mental health system.

- **Adequacy of Care:** Generally, the treatment Mr. Dix received during recent hospitalizations was appropriate, but the discharge plans were not. For example, immediately prior to and during the Brookdale hospitalization, Mr. Dix had assaulted five individuals, yet he was discharged to live on his own and to receive periodic clinic services. In view of his long history of non-compliance with medication and aftercare services and his recent assaultive behavior, Mr. Dix should have been referred to a more intensive treatment program, e.g., day hospital or continuing day treatment, where a psychiatrist is present daily to intervene as necessary. Referral to a clinic program was unsuitable. Put succinctly by one of the MRB psychiatrists, "He was simply too sick for this." Similarly, the failure of North General to actually secure an Intensive Case Manager for Mr. Dix seriously flawed that discharge.

**Recommendation:** In view of these findings, the Medical Review Board and the Commission recommend that all facilities discharging individuals with serious mental illness and a history of non-compliance with aftercare ensure, through training and supervision, that staff who prepare discharge plans are aware of and consider the full array of services in the community which may be needed to support the individual, and that case managers (see Housing and Community Supports at p. 12) are assigned responsibility to monitor compliance with clinical recommendations and prompt additional interventions when such are needed.

- **Family Involvement:** Throughout the course of Mr. Dix's treatment, his mother was a firm advocate for his receipt of appropriate services. On several occasions, Mr. Dix was discharged to his mother's care or to an independent living situation while she proposed instead that he be placed in a structured, supervised community placement.

**Recommendation:** The Commission recommends that the Office of Mental Health alert all hospitals to the provisions of State law governing the role of family members and other significant persons in the treatment and discharge planning process and ensure that these individuals are afforded a meaningful role in such decisions.

- **Housing and Community Supports:** Attempts to provide Mr. Dix with the type of structured housing that his mother advocated for and some clinicians believed he needed, often failed. Clearly, Mr. Dix's requests to go back to Creedmoor indicate his perception of its state-operated community residence as a safe haven for him where he would receive the necessary care and supervision to hopefully avoid rehospitalizations.

However, at times Mr. Dix was seen as a poor candidate for community-based residential programs certified by the Office of Mental Health due to his history of violence, poor insight into his illness, and non-compliance with aftercare services. At other times, Mr. Dix was seen as a potential candidate for, and was willing to live in, adult homes, and hospitals made application for such placement; but while applications were pending, he was given the option of being discharged early if he was willing to live in his own apartment. As he was, he was discharged.

As much as Mr. Dix needed a supervised living arrangement (his most successful period of community living following his first hospitalization was the nearly four year period he lived in the Creedmoor SOCR and the Leben Home), he needed individuals to relate personally to him, to coordinate his treatment and advocate on his behalf. Case managers in certified residential settings traditionally play these roles. But for an individual like Mr. Dix, who did not live in certified settings following his departure from the Leben Home, these roles could have been played by an Assertive Community Treatment (ACT) team member or an Intensive Case Manager (ICM).

The latter carry caseloads of 12 people and are expected to be the point of accountability for each person they support. An ICM would have been available to Mr. Dix 24 hours a day and would have attended discharge planning meetings; would have provided frequent reinforcement regarding the need to continue to take medication; would have monitored him for emerging symptoms; would have facilitated Mr. Dix's treatment from a consistent set of providers, instead of hop-scotching all over the city; and would have helped Mr. Dix cope with day-to-day problems.

Some seriously mentally ill individuals who, because of their illness, resist or avoid involvement with mental health services, respond positively to an ACT team. This interdisciplinary clinical team directly provides needed treatment, rehabilitation, and support services on a long-term basis to its clients 24 hours a day, seven days a week primarily in the client's setting, as distinct from a program site. In addition to treatment-related activities, the team helps consumers get financial entitlements, housing and non-psychiatric medical care. Commonly, an ACT team would include a psychiatrist, nurse, doctoral and master's level professionals, and a peer specialist (a person who is or has been a recipient of mental health services for a severe mental illness. Unlike the clinics that were to serve Mr. Dix, an ACT team does not drop persons from its program when they fail to keep appointments, but instead reaches out and brings services to them.

**Recommendation:** To ensure that hospitals have access to adequate residential services and/or necessary community supports to permit appropriate and prompt discharge planning, it is recommended that the Office of Mental Health conduct a comprehensive assessment of current housing resources – including, but not limited to, state and voluntary-operated community residences, supported living programs, etc. – as well as the current availability of ICM and ACT team community supports to determine the need for additional residential and community support services for individuals whose serious and persistent mental illness has represented a danger to themselves or others or has resulted in frequent rehospitalizations. It is recommended that the Office of Mental Health undertake this comprehensive assessment and develop a plan to address identified needs, with time frames for implementation, with input from other state agencies and local governmental units, as well as provider, family and consumer groups.

- **Assessing Histories:** Mr. Dix's frequent stays in a variety of hospitals and treatment in multiple mental health clinics made it difficult, if not impossible, for treatment facilities to assemble a comprehensive picture of his history with the tools presently available to facilities. The Commission and Board noted that a system needs to be developed whereby hospitals can, at a minimum, learn at what programs and in what facilities an individual has received treatment, so that inquiries can be made to these programs to assist the hospitals in their treatment planning for the person. One possible way to implement this recommendation lies in the Medicaid Management Information System which can produce a billing record for a Medicaid recipient. It can identify the programs which have billed for services on someone's behalf, without disclosing personal and confidential diagnostic and treatment information.

**Recommendation:** The Commission recommends that the Office of Mental Health, in collaboration with the Department of Health, review the feasibility of affording hospitals access to the Medicaid Management Information System, including necessary safeguards to prevent the inappropriate use or disclosure of such information.

- **Training Issues:** The Commission's Medical Review Board raised a number of issues regarding the adequacy of care afforded to Mr. Dix. In its review, two specific areas involving the need for appropriate training were identified. First, no single facility had a comprehensive understanding of Mr. Dix's treatment or his propensity for violence, especially towards women. The gathering of historical information, such as that undertaken by the Commission, would have enabled clinicians to make more effective decisions or ensure that Mr. Dix received adequate care and treatment.

**Recommendation:** The Commission and its Medical Review Board recommend that the Office of Mental Health alert and provide technical assistance to service providers encouraging the use of objective aggression scales which can be utilized to assess potential dangerousness, as well as securing detailed history from other providers and family members to promote effective treatment planning.

Secondly, throughout the course of his treatment, Mr. Dix often complained about the side effects of medications prescribed for him. Given recent development of newer anti-psychotic medications which often have fewer side effects, it is crucial that physicians have a comprehensive understanding of the range of medications available in order to promote successful community treatment.

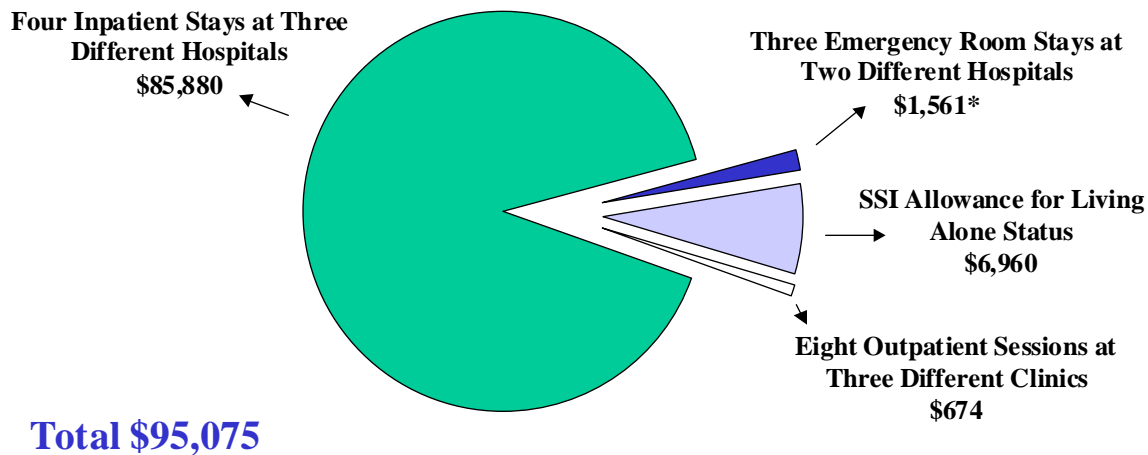
**Recommendation:** The Commission and its Medical Review Board recommend that the Office of Mental Health promote the continued training of physicians with regard to new and promising anti-psychotic medications and the benefits of such medications in dealing with patients who have a history of non-compliance with more traditional medications. Likewise, the Commission and its Medical Review Board also recommend that clinicians educate patients about the intended effects of medications and the management of side effects.

- **Monitoring and Managing Patient Violence:** On a number of occasions, Mr. Dix assaulted staff and patients of facilities where he was treated, jeopardizing individuals' safety and the therapeutic milieu of the treatment setting. Violent acts by patients must trigger clinical and other responses.

**Recommendation:** The Commission and Board recommend that in its revision of incident reporting regulations the Office of Mental Health ensure that patient assaults on staff and other patients are classified as incidents and investigated and managed as such, so as to reduce the likelihood of their recurrence, and are reported to OMH for monitoring purposes. It is also recommended that the Office remind facilities of their obligation to report apparent crimes, which would include assaults, to law enforcement officials.



## The Cost of Mr. Dix's Mental Health & Residential Care in 1998



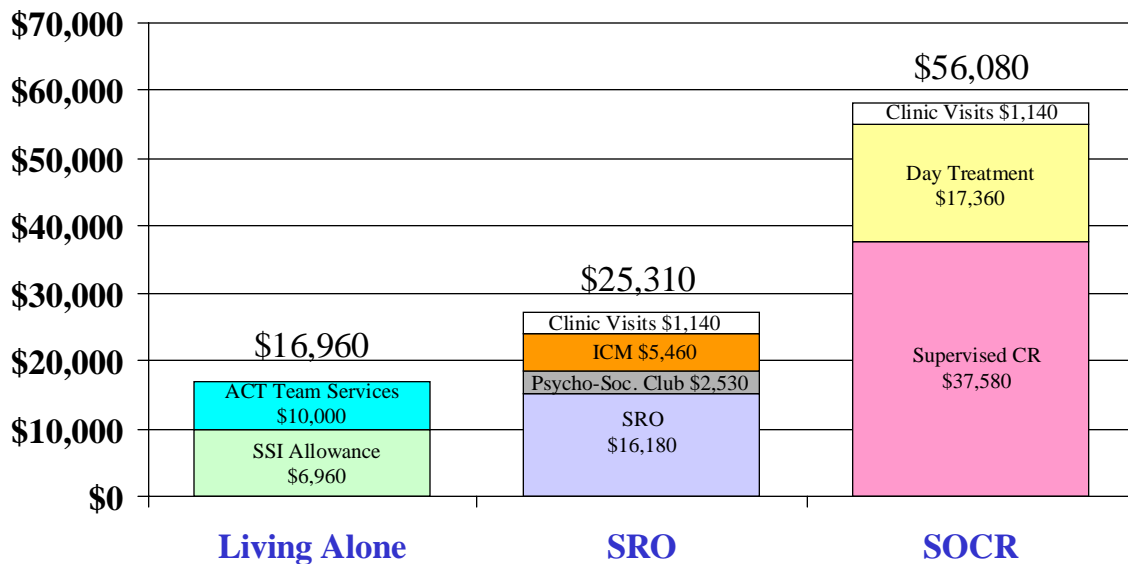
\* A 4th emergency room stay at one of these hospitals had not yet been paid by Medicaid at the time of the Commission's review.

- Cost Issues:** The Commission is cognizant of the finite funds available for the treatment and support of persons with mental illness. The Commission carries an obligation to ensure that its recommendations represent an appropriate and judicious use of public funds. The history of Mr. Dix's treatment documents numerous and frequent rehospitalizations in acute inpatient care settings. Although such hospitalizations would generally stabilize Mr. Dix, they did so at great expense. As noted previously, Mr. Dix's multiple emergency room visits and hospitalizations in the last year of treatment alone amounted to over \$87,000<sup>5</sup>. (Additionally, he received \$6,960 in SSI benefits for his private room and board.) Neither Mr. Dix nor the public were well-served by this fragmented and costly approach to care. For a fraction of that cost, Mr. Dix could have received the services of an ACT team (\$10,000 annually) while living alone on his SSI benefits, or resided in a supervised SRO with day services, clinic visits and an intensive case manager (\$25,310 annually)<sup>6</sup>, or resided in an OMH-certified community residence with related services (\$56,080 annually)<sup>6</sup>. Such community-based supports would have provided the structure and continuity of care Mr. Dix required while living in the community and may have reduced Mr. Dix's frequent and costly ER visits and inpatient hospitalizations.

<sup>5</sup> This does not include the cost of his medications, clinic visits or SSI benefits for room and board.

<sup>6</sup> These residential cost figures are based on recent OMH cost data for New York City dated July 1999.

## Cost Profiles of Three Alternative Residential and Treatment Approaches



**Recommendation:** The Commission and its Medical Review Board recommend that the Office of Mental Health, together with the Department of Health and Division of the Budget, examine means to utilize resources more efficiently and effectively to support the development of community services and decrease the repeated utilization of costly ER and inpatient hospitalizations by persons such as Mr. Dix.



**APPENDIX**  
**RESPONSE FROM THE OFFICE OF MENTAL HEALTH**



44 Holland Avenue  
Albany, New York 12229

Mr. Gary O'Brien, Chair  
Commission on Quality of Care  
for the Mentally Disabled  
401 State Street  
Schenectady, NY 12305-2397

Dear Mr. O'Brien:

The Office of Mental Health has received and reviewed the draft report, *In the Matter of David Dix\**, prepared by the Commission on Quality of Care for the Mentally Disabled which reviewed the care and treatment provided to Mr. Dix prior to January 3, 1999, when Mr. Dix pushed a woman to her death in the path of an oncoming subway train. On behalf of the Office of Mental Health, I want to thank you for your thoughtful review.

The care and treatment received by Mr. Dix prior to this incident deserves serious consideration. As noted by CQC, "in less than two years ... he was hospitalized eight times at five different hospitals and was treated in hospital psychiatric emergency rooms on at least seven occasions." In addition, his medication therapy, although consistent from provider to provider, did not include use of the latest anti-psychotic medications.

New York State operates the largest and most diverse system of mental health care in the nation, a system that is unparalleled in its commitment of resources. Notwithstanding, the New York State Office of Mental Health continually seeks ways to more effectively serve individuals with serious mental illness.

New medications and new therapies, which have emerged in recent years, have allowed more people to lead better, fuller lives -- and also required changes in the way services are administered.

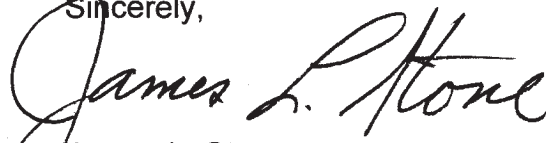
That is why Governor Pataki will be proposing a comprehensive package of new and innovative mental health initiatives including increased case management services and supported housing that, together with the latest science and treatments, will ensure that individuals with mental illness receive the best and most appropriate care possible for their needs.

\*Pseudonym

This comprehensive package will complement the recently enacted Kendra's Law, which provides for assisted outpatient treatment of certain individuals with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision. Such treatment shall include case management services or assertive community treatment team services to provide care coordination. The legislation also establishes a procedure for evaluating the need for involuntary hospitalization in cases where the assisted outpatient fails to comply with the ordered treatment. In addition, Kendra's Law provides grants to counties to provide medications and other services necessary to prescribe and administer medication to persons being discharged from hospitals, psychiatric centers and mental health units of jails and prisons during the pendency of a medical assistance determination.

Another major initiative of the Office of Mental Health is the development of Mental Health Special Needs Plans (SNPs). In July, OMH released the request for proposals for SNP's - a managed care option for Medicaid eligible adults who have a mental illness diagnosis and prior service utilization. One of the major goals of SNPs is to assure continuity of care through service coordination, networks and case management.

Once again, thank you for your draft report. We appreciate the Commission giving OMH the opportunity to review and comment on its findings and recommendations.  
Attachment

Sincerely,  
  
James L. Stone  
Commissioner

Attachment

**New York State  
Office of Mental Health**

**RESPONSE TO CQC RECOMMENDATIONS  
REGARDING MR. DIX**

**1) Adequacy of Care**

**“Recommendation:** In view of these findings, the Medical Review Board and the Commission recommend that all facilities discharging individuals with serious mental illness and a history of non-compliance with aftercare ensure, through training and supervision, that staff who prepare discharge plans are aware of and consider the full array of services in the community which may be needed to support the individual, and that case managers are assigned responsibility to monitor compliance with clinical recommendations and prompt additional interventions when such are needed.”

**Response:** The recommendation seeks to enhance the provision of proper discharge plans prepared by mental health providers through training and supervision. Such educational approaches are quite appropriate and are encouraged by the Office of Mental Health (OMH).

New York state operates the largest and most diverse system of mental health care in the nation, a system that is unparalleled in its commitment of resources. New medications and new therapies, which have emerged in recent years, have allowed more people to lead better, fuller lives and also required changes in the way services are administered.

That is why Governor Pataki will be proposing a comprehensive package of new and innovative mental health initiatives including increased case management services and supported housing that, together with the latest science and treatments, will ensure that individuals with mental illness receive the best and most appropriate care possible for their needs.

This comprehensive package complements recent significant actions, such as Kendra's Law, which contains provisions that will further enhance coordination of care and services, including, for example:

- 1 ) the assignment of a case manager or Assertive Community Treatment (ACT) team for assisted outpatients;
- 2) the provision of grants to counties to make available medication for persons with mental illness discharged from psychiatric centers, hospitals, and mental health units of jails prior to the availability of medical assistance; and
- 3) the identification and planning for provision of care coordination, emergency services, and other needed services.



- 4) the oversight of the program by the Local Government Unit (LGU) and State Office of Mental Health.

## 2) Family Involvement

**“Recommendation:** The Commission recommends that the OMH alert all hospitals to the provisions of State law governing the role of family members and other significant persons in the treatment and discharge planning process and ensure that these individuals are afforded a meaningful role in such decisions.”

**Response:** The OMH concurs with this recommendation and will implement such by sending out an alert to all licensed and state operated mental health providers encouraging them to include, at the patient’s request, significant individuals including relatives, close friends or other individuals concerned with the patient’s welfare, in treatment and discharge planning, consistent with part 33.02(a)(11) of the Mental Hygiene Law. In addition, OMH already has several initiatives underway that have sought to address these concerns. One of the recent ones has been the establishment of the Commissioner’s Family Liaison Program. This Program was created to strengthen the vital working relationship between consumers, families and State-operated and State-licensed mental health providers.

The Family Liaison staff work closely with other advocacy groups such as the New York chapter of the National Alliance for the Mentally Ill (NAMI) and its affiliate organizations across the state. Such organizations also provide channels for disseminating information to the community regarding the services available through the Program.

## 3) Housing and Community Supports

**“Recommendation:** To ensure that hospitals have access to adequate residential services and/or necessary community supports to permit appropriate and prompt discharge planning, it is recommended that the Office of Mental Health conduct a comprehensive assessment of current housing resources - including but not limited to, State and voluntary-operated community residences, supported living programs, etc. - as well as the current availability of Intensive Case Manager (ICM) and ACT team community supports to determine the need for additional residential and community support services for individuals whose serious and persistent mental illness has represented a danger to themselves or others or has resulted in frequent rehospitalizations. It is recommended that the Office of Mental Health undertake this comprehensive assessment and develop a plan to address identified needs with time frames for implementation, with input from other state agencies and LGU as well as provider, family and consumer groups.”

**Response:** OMH recognizes the need for enhancing the availability of services; As such, several initiatives are currently underway including increased capitol bonding authority and the recently enacted Kendra's Law. In addition, the OMH will continue to work collaboratively with counties through the local planning process so that clients in their geographic areas have access to services in the community which may be needed to support the individuals. The New York State Office of Mental Health utilizes the local government units with local knowledge to assess mental health priorities in their geographic areas and to monitor the utilization of existing resources, and will continue to work collaboratively with the counties. These actions will complement the previously noted package of proposed new initiatives.

**A. Housing.** The 1999-00 budget funds operating costs for over 22,1100 residential units for persons with mental illness. Several actions currently underway will increase the number of residential units by more than 2,800 over the next few years.

An example of these actions include:

The New York/ New York 11 Agreement provides for a joint state/city effort to develop housing for the homeless mentally ill in New York City. The targeted population served by this agreement are homeless mentally ill shelter system users and persons who reside on streets, or in parks, subways, and transportation terminals. The total placements anticipated under this new agreement are more than 2,300.

In addition, the recently enacted budget includes \$50 million in capital bonding authority for municipalities and not-for-profit community providers to develop approximately 900 new housing units (80% shall be matched on a 50/50 basis and 20% percent shall not require a match). Additional development underway includes previously authorized actions. In addition, these numbers do not include housing that may be developed as a result of the extension of the Reinvestment legislation.

In the last few years, the OMH has taken several steps to improve access and quality of the residential system. A few examples are:

- New York City Field Office staff meet several times a year with housing providers and state facility discharge coordinators on issues of access, to share best practices and other topics of special interest. Program reviews have been conducted with agencies which appear to have either long lengths of stay and/or a small percentage of state facility admissions.
- The Housing Unit has just completed a Supported Housing survey to determine whether Supported Housing has been implemented in a manner consistent with OMH guidelines. OMH is currently evaluating the data to ascertain whether revisions in the guidelines should be considered.
- Some counties in the state have initiated "single point of entry" systems for residential programs, with the intent of managing the local residential system in a

manner that will prioritize residential placement to those who are most in need of such services. The OMH is working with other counties to explore the possibility of initiating such systems elsewhere in the state.

**B. Community Supports.** Implementation of the Assisted Outpatient Treatment Law will contribute to the expansion of case management services and linkages to other community supports to facilitate treatment outside the hospital. The law specifies that an essential ingredient of treatment plans for recipients in the new service category, Assisted Outpatient Treatment programs (AOT), shall be case management or assertive community treatment team services to provide care coordination. The law also enumerates a variety of other community support services that may be in the treatment plan as appropriate. Emphasis on community supports in the Assisted Outpatient Treatment Law will be enhanced through the local planning process. This important initiative also provides for psychiatric assessments, medications, case management services, and education and outreach regarding the mental health proxy program.

#### **4) Assessing Histories**

**“Recommendation:** The Commission recommends that the OMH, in collaboration with the Department of Health, review the feasibility of affording hospitals access to the Medicaid Management Information System, including necessary safeguards to prevent the inappropriate use or disclosure of such information.”

**Response:** OMH will explore the feasibility of CQC’s recommendation, however, there are legal issues around confidentiality which first must be addressed.

#### **5) Training Issues:**

**“Recommendation:** The Commission and its Medical Review Board recommend that the Office of Mental Health alert and provide technical assistance to service providers encouraging the use of objective aggression scales which can be utilized to assess potential dangerousness, as well as securing detailed history from other providers and family members to promote effective treatment planning.

Secondly, throughout the course of his treatment, Mr. Dix often complained about the side effects of medications prescribed for him. Given recent development of newer antipsychotic medications which often have fewer side effects, it is crucial that physicians have a comprehensive understanding of the range of medications available in order to promote successful community treatment.”

**Response:** There are several standard aggression assessment tools, but the OMH does not promote the use of any single instrument. Rather, OMH has been promoting the use of a number of instruments to enhance clinical judgements, such as the PCLR and the HCR20, which assess risk globally rather than a single aspect such as aggression. OMH’s Bureau of Forensic Services staff have been participating in

Grands Rounds at state operated hospitals to encourage, educate and demonstrate the use of such scales. While on the non-state operated side, OMH has been working with counties and county jail staff around these issues.

With respect to CQC's comments about physician education on newer atypical medications, the Office of Mental Health does provide training opportunities for non-OMH professionals through Satellite Grand Rounds, the OMH Research Conference and other such training initiatives.

**Recommendation:** "The Commission and its Medical Review Board recommend that the OMH promote the continued training of physicians with regard to new and promising antipsychotic medications and the benefits of such medications in dealing with patients who have a history of non-compliance with more traditional medications. Likewise, the Commission and its Medical Review Board also recommend that clinicians educate patients about the intended effects of medications and the management of side effects."

**Response:** The OMH has been dedicated to training physicians in the use of new antipsychotic medications and will continue to do so. In OMH-operated psychiatric centers, use of the atypicals has been discussed regularly in semi-annual psychopharmacology training programs for OMH physicians. During such programs case studies, expert discussion, and dissemination of information stress the importance of these promising new medications. In addition, statistics on the percent of non-geriatric recipients prescribed these medications are included in an quarterly indicators report. This report is then used to track an individual facility's progress over time.

Additionally OMH offers many of its training opportunities beyond OMH professional staff. Among the current and ongoing initiatives to enhance physician education are the following:

- A. *Research Conference* - The main focus of the Annual NYS OMH Research Conference is education and technology transfer. The latest findings and current knowledge of researchers and educators are shared with clinicians, administrators, families, advocates, local providers and others. Roughly 1,000 individuals have participated each year.
  
- B. *Satellite Grand Rounds* - As part of its mission to provide and support continuing medical education to physicians both within the OMH system and beyond. Each year the Bureau of Psychiatric Services sponsors and coordinates a series of six or seven Grand Rounds lectures which are broadcast via satellite. The live audience for these programs has included OMH psychiatric centers, county service providers, and community hospitals and agencies from New York State. An even larger audience of service providers is reached through the broadcast of Grand Rounds. Over the past two years, approximately 15 to 20 percent of the program's total viewing audience came from non-OMH locations.

C. Clinical Practice Guidelines - The OMH has taken the lead in using clinical practice guidelines for the treatment of seriously mentally ill persons. These guidelines improve recipient care by disseminating knowledge to all stakeholders on the most appropriate and effective treatment. The development of best clinical practice guidelines has also made more efficient use of finite resources.

## 6) Monitoring and Managing Patient Violence

**“Recommendation:** The Commission and Board recommend that in its revision of incident reporting regulations, the OMH ensure that patient assaults on staff and other patients are classified as incidents and investigated and managed as such, so as to reduce the likelihood of their recurrence, and are reported to OMH for monitoring purposes. It is also recommended that the Office remind facilities of their obligation to report apparent crimes, which would include assaults, to law enforcement officials.”

**Response:** All programs operated or licensed by the OMH are required to have in place incident management programs consistent with the mandates of Part 524 of Title XIV the Official Compilation of Codes, Rules and Regulations of the State of New York NYCRR). These incident management programs are to be reflected in an incident management plan that is subject to OMH approval. The incident management regulations outline what such a plan should include. The essential components include the identification, documentation, reporting, investigation and monitoring of individual incidents and of incident patterns and trends.

Among the events to be identified as incidents and handled through the provider’s Incident Management Program are a wide range of occurrences, specified and defined in Part 524. Some types of incidents, such as homicides, suicides, unexplained deaths, allegations of abuse or neglect, and clients missing from inpatient or residential facilities, are, by definition, considered serious and immediately reportable to the OMH.

For other types of incidents, including assaults, the providers are required to identify, document, report, and investigate the incident and identify opportunities for improvement, devise plans of correction, if necessary, and monitor the implementation of such plans. Unless these incidents endanger the health or safety of recipients, staff or others, however, the current regulations do not require the providers to report these incidents to OMH.

Regarding the reporting of crimes, the incident management regulations require that all crimes committed by or against clients are to be identified as incidents and reported to Central Office. The regulations also remind the providers of their obligation to report all crimes to the appropriate law enforcement authorities.

The incident management regulations are currently under review, and revised regulations are anticipated which, among other things, will stress the importance of

reporting all crimes to both OMH and law enforcement authorities, with a particular emphasis on reports to OMH of crimes which affect or have the potential to affect the health or safety of one or more persons.

Further, the OMH has developed a new state of the art Internet based incident management and reporting system. This year OMH will be implementing this system in state operated facilities. During the year 2000, this too[ will be expanded for use in OMH licensed programs.

## 7) Cost Issue

**“Recommendation:** The Commission and its Medical Review Board recommend that the OMH, together with the Department of Health and Division of Budget, examine means to utilize resources more efficiently and effectively to support the development of community services and decrease the repeated utilization of costly ER and inpatient hospitalizations by persons such as Mr. Dix.”

**Response:** The comparison of the cost of Mr. Dix’s inpatient care during 1998 to other community-based alternatives needs to be assessed in context, taking into account all variables including, but not limited to: 1) that the total service cost for individuals residing in the community, whether in congregate treatment, supported Single Resident Occupancy (SRO) or “Living Alone” arrangements is highly variable, depending on the needs of the individual; and 2) receiving outpatient services while living in the community does not necessarily preclude inpatient hospitalization when appropriate.

A major initiative of the Office of Mental Health in promoting the development of an integrated and cost-efficient mental health system in the State of New York has been the move toward Medicaid Managed Care. Special Needs Plans (SNPs) are intended to promote a comprehensive, high quality system of services which is focused on the rehabilitation and recovery of individuals who are diagnosed with a serious mental illness.

Implementation of the SNPs, better use of other system-wide services such as ACT, Intensive and Supportive Case Management Services and further use of OMH’s existing Community Residence utilization Protocol by the Community Oversight Program will free up existing capacity in the system. This will create a flow from most restrictive levels of care (inpatient) to the least restrictive (the array of community residential options.) Additionally, this will provide a smoother and safer transition to community life, while offering more clinically appropriate and less costly settings for individuals preparing for discharge from inpatient settings.