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New York State Select Committee on Mental and Physical Handicap 1976-77 Annual Report

APPENDIX

VIOLENCE REVISITED!

A report on traditional indifference in State mental institutions toward assaultive activity

by Senator James H. Donovan

March, 1977

Introduction

News accounts of institutional violence and invitations by concerned parties precipitated the Select Committee's inquiry into conditions in state psychiatric centers.

The committee had elicited testimony concerning institutional violence and had received case histories in visits to psychiatric centers. As the 1976 committee hearing in Buffalo was being scheduled, reports of sexual violence and "coeducational wards" at Buffalo Psychiatric Center appeared in the Buffalo press.

The chairman directed committee staff to assess conditions at that institution before the December 1st hearing at Buffalo. The committee did, and made subsequent, similar inquiries at Marcy and Bronx Psychiatric Centers.

The committee's inquiry consisted in poring over thousands of incident reports at the three hospitals, talking with hospital staff and visiting wards.

The committee was alarmed to conclude that the Department of Mental Hygiene does not know what is happening in its institutions, a lack of knowledge that extends to institution directors themselves.

They do not know what is going on because the basic incident reporting system is a flop.

Each institution files a report on an unusual incident, i.e., assaults, fights, suicides, attempted suicides, medication errors, accidental injuries, sudden and accidental deaths, and patients leaving without permission.

Unlike the news account, the public hearing and the inspection of a hospital where violent acts have been reported, all of which tend to focus on the sensational, the incident reporting system should reveal overall conditions at each state mental institution. It does not.

The present system does not achieve this desirable goal because the reports are not aggregated, a process the department is now moving to implement.

The basic incident report serves to protect the hospital and its employees by providing documentation for those who inquire about incidents or injuries.

The committee aggregated reports at Buffalo and Marcy Psychiatric Centers for 1975 and the first ten months of 1976, and at Bronx Psychiatric Center from July through October 1976, using the hospital's figures for the first six months of 1976.

At all three hospitals, the committee extrapolated data from a minority of the total reports, the extrapolations being assaults and fights, medication errors, suicides and attempted suicides, sudden or accidental deaths, and leaves without consent.

Because that was not the purpose of the inquiry, the committee did not aggregate data on accidental injuries, which, the committee discovered, formed the majority of all incidents.

The committee has appended the tabulations for Marcy and Buffalo for 1975, and existing and proposed incident forms.

The committee also reviewed minutes and attendance of Boards of Visitors at the three institutions.

Part I

Violence in the Institutions

1. INTRODUCTION

The department, sometimes prompted by the news media, tends to concentrate on suicide, homicide and sexual rapacity in addressing itself to violence in its institutions.

However, extending the committee's samplings of violent incidents at Bronx, Buffalo and Marcy throughout the department's 28 psychiatric centers, the department experiences more than 12,000 violent incidents each year in all state psychiatric centers.

Incredibly, on the apparent assumption that many mental patients are given to violence, the department has made no systematic attempt to lower the number of these incidents.

Indeed, if the department were to begin today to reduce violence in problem areas, it wouldn't know where to begin.

Not only is the department unaware of which institutions harbor the most violence, institution directors are not aware of which of their units or wards are the most violent.

There is no department-wide reporting and compilation of institutional violence. Thus, if the department does not know such basic information as how many violent incidents there are in each institution, it cannot be expected to know when and where such incidents occur, how many involve employees, how violence relates to mixing of the sexes, or any other categorization that might lead to departmental moves to reduce violence, and thus, reduce injuries to patients.

The institution director is no better off than the department. Written reports of violent incidents are woefully incomplete. The vast majority give no indication of where employees were when the violent incident took place.

The committee reviewed incident reports at Marcy, Bronx and Buffalo. The review produced some surprising conclusions. For example, fully accredited and highly praised Marcy Psychiatric Center is every bit as violent as Buffalo Psychiatric Center, which has received a one-year, provisional accreditation.

The committee categorized violence into patient vs. patient, patient vs. employee, sexual violence, suicides, employee vs. patient and property damage. In some cases, these were broken down further according to sex.

2. PATIENT AGAINST PATIENT

Assaultive actions by one patient against another take a variety of forms, from pushing and scratching to throwing chairs and socking someone in the jaw. The majority produce minor injuries.

Some are painfully bizarre, such as a young male patient burning cigarette holes in two other patients at Buffalo, or a biting fight among two young males at Marcy, in which a penis was bitten.

Assuming the validity of incident reports at the three hospitals surveyed, and the committee assumes this only generally, data for the first 10 months of 1976 indicates that Bronx is more violent than either Marcy or Buffalo.

But Buffalo, which has recently been publicized for violent acts, appears to be no more violent than Marcy, which has not been subject to public scrutiny.

Recalling that Marcy has twice as many patients as either Bronx or Buffalo, Bronx had 334 patient vs. patient encounters in the first 10 months of 1976; Buffalo, 123, and Marcy, 392.

Buffalo and Marcy were reviewed for all of 1975. Buffalo had 165 patient vs. patient incidents' Marcy, 556, or 3.5 times as many as Buffalo.

Although there were reductions in patient populations at Marcy, it would not explain the sharp drop from 46.3 patient vs. patient incidents a month in 1975 to 32.7 incidents a month in 1976. Buffalo showed a slight increase in 1976 over 1975, from 12.3 a month to 13.7 a month.

These were the percentages of violent incidents at the hospitals, proportioned according to whether they were male against, male, male and female, or female against female:

	1975			1976*		
	M-M	M-F	F-F	M-M	M-F	F-F
Marcy	52.7	1.1	46.2	51.9	2.3	45.8
Buffalo	48.8	15.4	35.8	40.7	18.6	40.7
Bronx	—	—	—	47.1	23.6	29.2

* The 1976 percentages are for January through October at Buffalo and Marcy, and for the four months ending in October at Bronx.

The most significant distinction would appear to be the far lower rate of male-female violence at Marcy. At the same time, Marcy has the greatest rate of female-female violence.

For the 22-month survey period, Marcy had 948 incidents of patient vs. patient violence, of which 435 were female against female, or 45.9 per cent. There were only 16 male-female incidents, or only 1.7 of the total.

Marcy, it is remembered, practices more rigidity between the sexes than does either Bronx or Buffalo. The speculations are obvious, including the observation that less sexual integration might not reduce violence, but rather recategorize it.

None of these male-female altercations involve sexual intent. These are covered in another section of this report.

The survey also revealed which of the wards in the hospitals experienced more patient violence. Wards at Marcy having 10 of more incidents in 1975 were A-2, B-11-12-18-19-21-26-27, D-42-43-45, E-50-52, E-65, G-72-75-76, and Crane Hill School 80-82-83.

At Buffalo in 1975, they were Wards 62 and 72 in the South Unit and 80, 81 and 84 in the North Unit.

In the four months reviewed at the Bronx for 1976, wards having seven or more incidents were 5, 10, 23, 31, 32 and 35.

In 1975 at Buffalo, the medical-surgical wards had no violent incidents; geriatrics and geriatric admissions, 41 patient vs. patient incidents; and unitized services, 107. Geriatrics wards thus formed 27.7 per cent of the total. In 1976 at Buffalo, geriatrics wards produced 12.4 per cent of the total.

At Marcy, for the 22-month survey period, geriatrics wards experienced 2.8 per cent of the assaultive incidents; adolescent and children's wards, 19.5 per cent.

The abovementioned patient vs. patient figures include both the categories of patient fights and assaults that are listed on incident reports.

3. SEXUAL VIOLENCE

The committee's review of incident reports revealed fewer instances of sexual violence at Marcy than at Buffalo or Bronx.

Marcy, with a far greater inpatient load, but with greater separation of the sexes than either of the other institutions, reported only two cases of sexual assault on hospital grounds during the 22-month review period.

One of these occurred when a female patient assaulted another female in bed. The other happened during a necking exercise in a building basement when the male refused to halt the proceedings and the female did. Marcy reported another case where a female prisoner on pass was raped.

Bronx reported nine cases of sexual or suspected sexual assault in 1976. Buffalo reported four sexual assaults in 22 months. Each reported one case of patient assaulting a female employee.

Marcy mixes the sexes for program and social activities, as do the other hospitals, separating the sexes on the wards only.

The differences among the hospitals in levels of rapacious sexual activity produce obvious questions: Is Marcy's greater control of movement between the sexes responsible for its lower incidence of sexual violence? In exercising greater control, is Marcy reducing therapeutic benefits; Does Marcy, in fact, exercise greater control than either Bronx or Buffalo?

The hospitals are set in different environments. Do Bronx and Buffalo receive different "types" of patients as a result of those settings? Are these environments in part responsible for the greater level of sexual violence and overall patient violence at the Bronx?

Bronx has compiled data showing that, among the five New York City boroughs, it has the lowest per capita income and the greatest percentage of people on Medicaid.

In any event, the committee believes, in becoming aware that one institution has a greater incidence of sexual and overall violence, the department should at least ask why. The determination having been made, the department should act forcefully and swiftly to reduce the incident level at the institution with the greater violence.

4. PATIENT AGAINST EMPLOYEE VIOLENCE

Incident reports at the three hospitals indicate that, in the majority of cases, patients do not lash out at employees without a stimulus. Sometimes it occurs when an employee intervenes in a patient fight, or while an employee is attempting to restrain a highly disturbed patient.

A comparison of patient vs. employee incidents at the three hospitals reveal a significant difference.

Marcy, with far more patients, has far fewer incidents of such assaultive acts than either hospital, with 19 for the first 10 months of 1976, compared with 27 at Bronx and 29 at Buffalo for the same period.

In 1975, there were 35 such incidents at Marcy, but 105 at Buffalo. It should be noted that Marcy incident reports rarely mention or describe injuries to employees, whereas at Buffalo, they appear to concentrate on doing so.

While female patients appear to engage in nearly as much violence against other patients as do male patients, they appear less likely to assault employees.

At Marcy, only one assault against an employee by a female was contained in 19 assaults against employees in 1976. During the 22 months surveyed, of 54 assaults against employees, only five were by women. At Buffalo in 1975, of 38 assaults in which the sex of the assailant was indentified, 15 were by women.

5. THE TROUBLESOME PATIENT

Although in the course of any considerable time period, many mental patients engage in violence, a certain few make it a specialty.

In wards with relatively high frequencies of violence, it is not uncommon that one patient is responsible for a large part of it. It is just as common that the patient responsible for the violence remains on the ward where he or she is causing the violence.

Through last November, Buffalo had no wards to house regularly disruptive patients, so such patients remained on the wards where they were assaulting other patients. One incident showed a patient transferred to another ward after he demonstrated a fear of a patient who had assaulted him twice.

Bronx and Marcy have wards for patients given to violent behavior, but their incident reports show that not all of the violent patients are assigned there.

At Bronx, patient S.D. was involved in seven fights or assaults in eight months; patient J.R., in five assaultive incidents in seven months.

At Buffalo, a short, wiry patient, J.L., described by staff as "knowing no fear," was involved in seven incidents in nine months. Female patient I.A. was in fights or assaults against other females eight times in three months.

At Marcy, patient M.G., generally the assailant, was in 20 violent incidents in 1975. Female patient V.C. was in 14 such incidents, six of them assaulting the same woman on the same ward.

Another female patient, K.B., who professed that she "just liked to hit people," did so nine times in 1975.

In all, Marcy had 17 patients in 1975 who participated in five or more assaultive incidents. They accounted for 157 of the 411 patient vs. patient or patient vs. employee assaultive incidents that year.

These 17 patients—out of 1,526—thus accounted for 38.2 percent of all the assaultive incidents at Marcy in 1975 (a percentage that would be reduced slightly to allow for duplications in which some of the 17 assaulted each other. The co-champions of Ward G-72, accounted for 22 of the 32 assaultive incidents on their ward, but never fought each other.)

Not only do institutions not tabulate violence records for individual patients, more importantly they do not keep track of the loser's records.

As cited above, one female Marcy patient was attacked by another female six times on the same ward, yet they remained housed together. A young male patient was either assaulted or lost fights eight times in 1975 at Marcy.

The committee is thus compelled to ask, at what point in time do the institutions believe that a patient should be removed from a ward if the patient's assaultive behavior doe not improve?

It should be pointed out, as one department official suggested, that any ultimate determination of ward-by-ward violence, should not occur without discerning the level of violence-quelling drugs on the ward. A ward with a relatively low violence level could achieve that status by a high use of such drugs, conceivably producing much less in the way of optimum patient care and treatment than a more violent ward.

The review of incident reports produced a further disturbing conclusion: The docile, withdrawn person who has never known violence in his or her life may find it for the first time under assault by a different kind of patient in a state mental institution.

6. EMPLOYEE AGAINST PATIENT

Incident reports at the three institutions do not reflect the harsh public accusations of patient abuse by employees.

Generally, the few incident reports of such activity cite the allegation and provide an explanation of the facts that tend to exonerate the employee.

The incident report, and any accompanying statements, are therefore inadequate to assess the culpability of the employee.

Marcy incident reports showed four allegations of patient abuse by an employee in 1975, none in 1976. Buffalo reports showed none in the 22-month period. Bronx reported three in 1976.

The committee rejects these figures in toto, which is not to suggest that the department or its institutions are covering up patient abuse, but rather that incident reports are an unreliable means of calculating such incidents.

The department's own study of patient abuse hearings indicates that the report figures at the institutions might be higher, particularly because the incident report is only an allegation, whereas the hearing is undertaken only after an institution director believes that sufficient evidence exists to warrant disciplinary action. The number of incident reports should be somewhat higher than the number of hearings on patient abuse, which, the department reported, totaled 594 over 30 months in all state institutions.

The departmental study was initiated in 1975 after the committee inquired as to whether the department had compiled data showing which institutions had the greatest number of disciplinary actions and how many such cases there were in the department. It hadn't.

7. SUICIDES

If there were a single glaring disparity among the hospitals in serious incidents, it was in suicides.

Marcy, with more than twice as many inpatients as either Bronx or Buffalo, showed no suicides for either 1975 or 1976. Bronx had 12 for 1976 alone. Buffalo had two in 1975 and four in 1976, of which two were off-grounds.

If the department has been indifferent to accidental injuries and "normal" patient violence, it has shown concern over patient deaths and suicides, particularly those that have been publicized.

However, that concern has not been reflected in results.

The chairman and the committee toured Bronx in 1975 and observed a side room where a female patient

had hung herself a few days earlier. There was no reason for the room to be open at the time of the suicide.

The committee's hearing in Manhattan that year produced testimony revealing substantial concern over suicides and other violence at Bronx. And yet, the next year there were a dozen suicides there.

At Buffalo, a woman attempted suicide by cutting her wrist on June 12, 1975. Six days later at 4 PM, she did the same thing. Five hours later, she was dead, having jumped from a seventh floor utility room. The incident review committee declared that "proper procedures had been followed."

The committee questions further why the department, presuming the department is aware that people are committing suicide in rooms not used by patients, does not issue a blanket order requiring that such rooms be locked.

8. PROPERTY DAMAGE

Neither the department nor its institutions complies information on property damage by its patients. Incident reports often reveal such damage in the course of describing an injury to a patient.

A Bronx patient was described during the committee's 1975 visit as having smashed more than a dozen television sets.

Buffalo's incident reports revealed 11 property incidents in 1975. Marcy recorded 52 such incidents in the 22-month period, of which 38 were male and 14 female. The majority were broken windows. During one of the Buffalo incidents, 11 windows were broken.

9. COMMITTEE RECOMMENDATIONS:

1. The incident reporting form should be changed immediately to permit identification of all parties in assaultive incidents.

2. Employees at, near or involved in assaultive incidents should be identified on incident reports.

3. Information should be compiled first on an institution basis, then department wide, indicating where the greatest incidents of violence exist.

4. A patient care and safety team should be established to investigate problem institutions and wards at any institution for inordinate levels of suicides, sexual assaults and overall violence.

5. Cumulative record-keeping that keeps track of problem patients' violence should be undertaken, thereby permitting those patients to be identified and their violence measured.

6. Regularly violent patients should be moved to more restrictive and secure surroundings, and conversely, withdrawn, harmless patients who have been assaulted should be moved to wards where their safety can be assured.

7. Property damage should be calculated as a factor in the prevalence of violence at any institution.

8. Most importantly, a departmental attitude that accepts a certain level of violence as routine for any mental institution should be replaced with an attitude that augurs for its reduction through the belief that such reductions are indeed possible.

Part II

Non-Violent Incidents

1. INTRODUCTION

The overwhelming majority of incident reports filed at state institutions have nothing whatsoever to do with violence.

The largest single category is accidental injury, frequently a mark, bruise or small cut discovered on a patient at showering or undressing.

Department institutions also prepare individual reports on accidental and sudden deaths, medication errors, and leaves without consent (which include escapes, the distinction applied to court-mandated admissions).

The committee believes that the department should be much more concerned with reducing the number of incidents in each of these categories, particularly accidental injury.

2. ACCIDENTAL INJURIES

Public scrutiny and departmental attention on care and treatment of patients in state mental institutions has focused on patient abuse, as it is caused by employees, and more recently, as it is caused by other patients.

Reports of such abuse at Buffalo precipitated the committee's first inquiry into hospital problems and the manner in which the department copes with them.

In reviewing incident reports, principally to extrapolate violent incidents, the committee was shocked to discover that for every patient injured in a violent incident, there were three others injured accidentally.

To be sure, many, and possibly most, of the accidental injuries are minor, as are most of the injuries suffered during violent incidents. But many are not.

If there were one significant cause of accidental injury, it was the fall. The simple fact is that patients are falling all over our mental institutions.

They fall getting in and out of bed and while they are in bed. They fall getting in and out of chairs. They fall going to the toilet. They fall out of wheelchairs. They fall while they are dressing and undressing. They fall while walking, frequently slipping on urine.

Although the committee did not categorize or otherwise compile data on falls or other accidental injuries, it is the committee's belief that two-thirds of all institutional incident reports are either falls, or bruises, marks or cuts discovered on patients by employees.

The committee concludes that by far the greater number of injuries suffered by patients are the results of accidents and not of patient or employee violence.

To the committee's knowledge, neither the department or any of its institutions is reviewing occurrences of accidental injury to determine their prevalence as to cause, location and time.

With relative ease, the incident report court be designed so that it would show time, place and cause of falling, thereby permitting institutions and the department to focus on prevention.

COMMITTEE RECOMMENDATION: The department should change immediately the incident reporting of accidental injury, so that each institution and the department can be made aware of where and how it occurs. Semiannual and annual reports for the same purpose should be filed with regional directors and central office.

Once the principal areas of falls and other accidental injuries are identified, a concentrated effort to reduce their frequency should be undertaken.

3. SUDDEN DEATHS, ACCIDENTAL DEATHS

The department regularly compiles death statistics for its institutions and manifests a genuine concern over institutional death rates that appear high.

The same concern and desire for improvement is shown especially for suicides and homicides.

However, there is no departmental focus on categorizing accidental and sudden deaths, and apparently there is considerable confusion as to their definitions.

At Buffalo, the hospital reports few "sudden deaths" within the institution. The typical sudden death reported at Buffalo is a Family Care patient suffering a heart attack. At Marcy, a patient found dead in bed is recorded as a sudden death, and these constitute the majority of Marcy sudden deaths.

A review of incident reports at Buffalo and Marcy indicates that the department tends to exonerate itself in those cases where the sudden death follows an accidental injury or other incident.

The reports do not reflect an inquiry into either whether the physical condition of the patient could have caused the accidental injury or whether the accidental injury could have exacerbated the physical condition to the point of causing death.

At Marcy, in November 1975, a female patient found her way to an elevator blocked by another female patient. The report did not indicate whether either woman was acting belligerently. The woman attempting to get on the elevator fell, severely enough to break four teeth and suffer abrasions. She died in bed the next day. An autopsy revealed a massive pulmonary embolism, and thus the death was not attributable to the fall.

At Buffalo, in May 1975, a patient chocked on food. His death was attributed to a "massive heart attack" by a pathologist.

Two 1976 Marcy deaths that followed falls were similarly attributed to a physical malfunction.

Four of Marcy's twenty sudden deaths in the 22-month survey period followed falls.

The committee suggests strongly, that in rejecting accidents as contributory causes of subsequent deaths, the department is sweeping its responsibility under the rug of a physician's venacular that describes death causes as those that prevented the body from continued functioning at the time of expiration.

The chairman emphasizes, once again, that it is an egregious mistake, as the governor has done, to place the responsibility for investigating departmental deaths entirely in the hands of physicians.

As is the case in our institutions now, the physician can diagnose the immediate cause of death, but they are no better equipped than window-washers or bank presidents to analyze the events leading up to the death.

COMMITTEE RECOMMENDATION: The governor's death review board for the department should be revised to include non-physician members.

The Department should categorically review its non-violent deaths to determine how factors other than "natural causes" have influenced death rates.

4. MEDICATION ERRORS

Medication errors generally occur when a patient gets the wrong medicine, too much or too little medicine, or is not given medicine.

Medication errors are reported as incidents by all institutions, although the form of the report varies. They are not reported categorically within the institutions or by the department.

As a result, neither the department nor the director has any significant, cumulative data to indicate weak areas in the dispensation of medicine.

Like all other categories of incident reporting, the department can only guess as to which institution does the best—or worst—job of supervising medications.

The committee's review of medication errors at the three hospitals surveyed revealed enormous disparities between institutions and concentration or medication errors within institutions.

In each case, they were significant enough to raise serious questions—either about the reporting or about the actual dispensation of medications.

Bronx reported only eight medication errors in 1976, compared with 37 at Marcy. Marcy had 64 medication errors in 1975; Buffalo, 30.

It could be concluded, therefore, that Bronx is controlling medications in a manner far superior to Buffalo and Marcy, or something is wrong with the reporting system. In any case, such a disparity is worthy of a department inquiry.

The reports revealed that 80 per cent of all the medication errors at Buffalo occurred in nine geriatrics wards. At Bronx, six of the eight errors occurred in medical-surgical wards. At Marcy, the errors tended to be spread through the hospital, although 35 per cent of all errors involved female patients in the 20-ward B Building.

The greatest number or errors in a single ward was nine—in Ward 23 at Marcy in 1975. (The same ward had only one error in 1976.)

The standard state incident reporting form is inadequate for reporting medication errors and like other incidents, requires the reading of a hand-written narrative to determine what occurred. Bronx has its own medication error form, which is an improvement on the state form, particularly because it enables the reader to determine who committed the error immediately.

COMMITTEE RECOMMENDATION: One standard form for reporting medication errors should be established for all institutions. Such a form would enable quick identification of the person committing the error and of the nature of the error.

Medication errors should be compiled monthly by ward and unit, for submission to the institution director, and semiannually and annually for submission to the director, regional director and central office.

5. LEAVES WITHOUT CONSENT AND ESCAPES

Leaves without consent, or patients leaving their assigned areas without permission, form a substantial portion of any hospital's incident reporting.

Bronx reported 153 LWOCs in the first ten months of 1976. Buffalo reported 97 in 1975. Marcy reported 345 LWOCs in the 22-month survey period.

It is a rarity when any other problem ensues from the LWOC. Most often, the patients return by themselves, or are returned by their families, staff or police.

The committee's survey showed, as might be expected, that there were far fewer LWOCs in December, January, February and March than there were in other months. At Marcy, the LWOCs were broken down by sex. They showed that males left twice as often as females.

It also showed that LWOCs tended to be concentrated in certain wards.

At Buffalo in 1975, two-thirds of all LWOCs were from the North Unit, and more than half the total were from Wards 81 and 83.

At Marcy, 60 per cent of all LWOCs were from five Adolescent wards. Half of the total were from Building E, which housed three of the Adolescent wards.

If there is a reason for pinpointing high LWOC areas, and attempting to reduce their occurrence, it is the time required to handle each incident.

Each time a patient is reported missing, a variety of parties must be notified. They spend time looking for the patient. If the patient is found away from the institution, staff are sometime sent to return him. Frequently, the staff that is sent are ward personnel, thus leaving the ward short of staffing.

Further, police called upon to help locate LWOCs are sometimes not happy with what they regard as open door policies of hospitals. Buffalo police in the precinct that covers Buffalo Psychiatric Center suggests that the open door policy applies to patients leaving. They believe that the door is closed to patients trying to get in.

The committee survey showed that almost twice as many patients leave Bronx and Marcy each month as do patients at Buffalo. This is another instance where a compilation of figures might lead the department to ask why.

COMMITTEE RECOMMENDATION: There should be a single incident report form for LWOCs It should indicate whether the patient left the grounds or was discovered before he did.

The LWOC incident reports should be aggregated semiannually and annually for submission to institution directors, regional offices and central offices.

The department should subsequently determine how much staff time is lost looking for the thousands of patients that leave institutions each year, and which hospitals spend more time at it than others.

Given the state's fiscal crisis and the concomitant cries of institution directors about lack of staff, it is not unreasonable to suggest that the thousands of man-hours that go into retrieving truant patients could be better spent looking after patients' welfare while they are in the institutions.

6. PRIVACY AND VOLUNTARY SEXUAL ACTIVITY AMONG PATIENTS

New York State does not guarantee privacy to residents of its mental institutions.

Privacy between the sexes depends much more on how the institutions are built than on departmental policy, which is to provide as much privacy as possible.

Sleeping arrangements vary widely, many of them forced by consolidations within institutions.

At Buffalo, in all geriatrics wards there is free movement between male and female sleeping quarters, either through halls or through bathrooms.

At Bronx, some wards separate male and female beds by partitions.

At Marcy, male and female wards are separate and there is no mixing during sleeping hours.

At Elmira, which the committee visited in 1975, and at Hutchings in Syracuse, which the committee visited in 1976, the patients sleep in single or double rooms. Male and females do not share the same rooms, but share the same wards.

At Buffalo, in the medical-surgical-geriatrics building, the wards were designed with one large bathroom to serve one sex. These five or six-stall bathrooms are now used by both sexes regularly, except in an all-female ward and in a ward where most of the patients are non-ambulatory.

With male and female patients now on the same wards, and given the incontinence of many older patients, there is no way that Buffalo will end bathroom mixing short of resegregating the wards, or construction or reconstruction of bathrooms. Buffalo has announced its intentions to do both.

The most important element in assuring toilet privacy is distance between the toilet and its users, particularly for elderly patients. Infirm, slow-moving patients are not likely to walk an extra 20 or 30 feet regularly to a bathroom serving their own sex when a bathroom for the opposite sex is closer.

At Syracuse, the male and female patients each have a single toilet for each eight-bed unit.

At Marcy, the wards are separate so there is no bathroom privacy problem.

Officially, the department disapproves of voluntary sex on the mental hygiene campus, but attitudes and practices of departmental personnel vary among and within institutions.

At Buffalo, a couple were discovered having intercourse in a single bedroom. They were advised by a staff psychologist that the incident was not inappropriate behavior. The psychologist was overruled by a psychiatrist and the parties were informed that they should not engage in such activity.

Incident reports at Buffalo, Marcy and Bronx would indicate that there is more voluntary sexual activity at both Buffalo and Bronx, which do not practice rigid segregation, than at Marcy, which does.

However, the lack of any significant incident reporting on voluntary sexual activity precludes any accurate determination of such activity.

Marcy reported one case of voluntary sexual activity in 22 months, but only in the course of explaining an LWOC. Buffalo reported four in 1975; Bronx, four in ten months of 1976. (One of Buffalo's was an alleged intercourse in a bathroom.)

These skimpy figures do not an argument make. However, it appears reasonable to conclude that the segregated living and institution attitude at Marcy contribute to Marcy's apparent paucity of voluntary sexual incidents.

The committee believes strongly that it is more than fallacious to suggest, as is done within the department from time to time, that sexual activity in state mental institutions is no greater than it is outside mental institutions. Lives of people in mental institutions are supervised 24 hours a day. They are not supervised outside institutions.

At one time, all wards in state institutions were segregated by sex. It is interesting to observe, that as the mixing took place, the department did not measure its impact, both on voluntary sexual activity and on violent sexual activity.

Indeed, the literature on effects of mixing patients by sex in mental institutions is as scarce as funding for community mental health. To the committee's knowledge there is no such study involving institutions in New York State.

Most of the literature is foreign in origin. Generally, it is written with the bias of an innovator attempting to prove himself right. These studies generally describe the therapeutic benefits and do not address themselves to the disadvantages of mixing the sexes.

These include: Ortega, 1962, at Littlemore Hospital, Oxford, England, a promotion for, rather than an analysis of, ward mixing; Mandelbrote, 1965, also at Littlemore, which concentrates on results of reorganization during the same period, and not on impact of sexual mixing; Costello-Gazan, 1962, at Regina General Hospital, Canada, which related improvements in behavior, but which reported on the mixing of only three males with 20 females in each of two wards; Morgan-Rogers, 1970, St. Wulstan's Hospital, Worchestershire, England, which deals principally with patients showing an interest in the opposite sex; Gligor-Tryon, 1973, V.A. Hospital, Brecksville, Ohio, a report on the mixing of eight males and eight females, finding that

females deteriorated in their emotional status and that males improved, but did not reach the preintegration functioning of females; and Loten, 1975, at Cornwall Geriatrics Hospital, Auckland, New Zealand, which involved only geriatric patients and did not discuss problems of mixing.

Policies on voluntary sexual activity in state mental institutions is that set by institution directors. If that is the case, and if there is no reporting of sexual activity, then it is clear that one institution could permit more such activity than another and no one would know about it.

State-wide, voluntary sexual activity does not appear to be a major problem in mental institutions. However, if it ever becomes a problem, both the department and the people of the state will be a long time knowing about it.

COMMITTEE RECOMMENDATIONS: The department should make a sincere effort to protect the privacy of each of its citizens in mental institutions. An Erie County person who places grandmother in Buffalo Psychiatric Center has every right to expect the same privacy afforded the grandmother of a Herkimer County resident at Marcy.

The department, in due course, should make some attempt to determine the impact of mixing the sexes in sleeping arrangements and otherwise. If Bronx allegedly permits too much sexual activity, then Bronx policies and practices should be compared with Marcy's.

The department should devise a means of reporting voluntary sexual activity that does not involve the use of patients' names, in order to protect their privacy. Until such a reporting system is instituted, the department will not be able to gauge the level of such activity, and will not be able to measure the impact of the so-called "coeducational living".

Part III

Incident Reporting

The Department of Mental Hygiene requires that each institution file a report on unusual incidents and supplies the forms to do it on. The completed forms rest in a repository of the institution director's choosing.

They have the useful purpose of serving as the starting point for an investigation into a serious incident by a special in-house incident review committee, or by the director.

Most often, however, they serve as a self-protection device for employees and the director, enabling them to provide explanations of incidents to families, regional directors and central office.

Thus, if a relative sees a welt on a patient's shoulder, the incident report is documentation that the department has discovered the welt, and perhaps, has a written explanation of how it got there.

There has been little department-wide or institutional impetus to use incident reports to pinpoint problem areas, thus enabling the department to implement corrective measures in problems institutions and directors to act similarly with problem wards.

It could be contended that the department can surmise which of its institutions are the most violent, and that directors can generally indicate which of their wards are the most violent.

The committee submits that neither the department nor few of its directors could immediately prove their conjectures, although subsequent analyses might prove them right—or wrong.

Newspaper headlines establish the violent reputations of certain of the state's mental hospitals. There are no department studies to support or refute the media messages.

The simple fact is that all incidents are handled on an individual basis. There is little or no aggregating that would mark institutions, wards or units as more susceptible to violence than others.

In reviewing thousands of incident reports, the committee concluded that the basic report form was an obstacle to proper incident reporting, that employees need much more instruction on how to fill them out, and that with little extra work, a reporting system could be devised that would enable the department to know what is going on in its institutions.

The present form requires the employee to provide information on the patient, check a box indicating which incident category applies, and describe the incident. The ward charge attests to that information, after which the doctor's findings are recorded, if the matter requires a doctor's attention. There is space for the review committee's findings.

Because employees frequently cannot distinguish among accidental injuries, patient fighting and assaults, it is always necessary to read the incident description to determine what occurred.

If one patient knocks another down with no provocation, that is clearly an assault. Yet, some incident reports check off such an incident as an accidental injury.

At Marcy, some accidental injuries were checked off as accidental deaths.

Some narratives of incidents are poorly written; some nearly illegible. Much of the narrative is frequently unnecessary.

Most of the time, the incident report does not

reveal where the employees were at the time of the incident.

There are no descriptions of the participants in violent incidents. Thus, a 250-pound man could slap a small man or woman and the report would not reflect the disparity.

At Marcy, incident reports do not reveal ages, as Marcy uses a 1972 form. Thus, a young, active patient could assault an elderly person and the report would not reflect the difference.

If the later, 1975 form is used, the age of an assaulted party would be recorded, but not the age or any other information about the assailant.

The report is filed in the name of the injured patient, and the information it contains is sufficient only to explain the injury, unless the reporter chooses to provide more. One report might reveal only that a patient was "hit by another male patient", while another report might show that the patient was struck after he was denied a match by another patient.

The most underdeveloped reporting occurred in those cases where a patient was being restrained or being placed in restraint by employees. "Injured while being restrained", or "hit his head on the floor while being restrained" is usually the sum total of the information provided for these incidents, although they are clearly very physical patient-employee encounters.

The reports are reviewed individually, by the review committee and the director, for certain periods of time.

If a review committee meets every two or three weeks, it will scan the reports for those two or three weeks. They are reviewed on an individual basis, with little relationship to incidents of the past.

Thus, if one patient assaulted others twice in the review period, only these incidents are reviewed. If the patient has assaulted five other patients in the two months preceding the review period, the committee might not reflect on it, or even be aware of it.

The reports are not aggregated. Thus, the department and its directors, excluding deaths, do not know which of their 28 hospitals or hundreds of wards experience the most violent incidents, the most medication errors, the most leaves or anything else.

Some attempts have been made at the institutional level. Marcy took a selected period to try and determine whether there was a difference in numbers of incidents among the three shifts. There was not.

Marcy also took selected periods in two different years to try to determine whether there was an impact on incidents because of the transition that is going on there. (The department has announced that Marcy will be consolidated into Utica Psychiatric Center and that Matteawan will be moved to Marcy.)

Bronx went back and reviewed a seven-month period from August 1974 to February 1975 for assaultive incidents by day, month, unit and time period.

Its report showed 116 violent incidents, or 16.5 a month. The committee's review showed 38.5 violent incidents a month in 1976, a large disparity.

It should be emphasized that knowledge of the total number of incident reports filed monthly or annually by a hospital does not reveal conditions within the hospital.

Only if they are broken down into accidental injuries and deaths, suicides, assaultive incidents, medication errors and leaves without consent do the numbers take on any meaning.

No need exists to use an incident reporting system as a means of flagging serious incidents. It is a safe presumption that hospital directors would know of rapes, murders, suicides, unusual deaths and employee abuse of patients without the incident reporting system. A simple directive ordering the reporting of these events would achieve this end.

The incident reporting system, then, enables the hospital to cover itself by having written explanations about what happens to its patients.

It is rarely used as a means of improving care and treatment of patients in mental institutions in New York State.

In the past few months, the department has moved to improve its incident reporting form and has conducted pilot studies using a revised form from which information can be computerized.

The committee applauds the move, and has discussed the revised system with department officials. Although the committee maintains reservations about the proposed form, it will improve the present system and enable the collection of data that will enable the department and its directors to make decisions based on that data.

COMMITTEE RECOMMENDATIONS:

1. Five separate incident reporting forms, each of a different color—one each for accidental incidents, violent incidents, medication errors, leaves without consent, and suicides and attempted suicides. These could be consolidated into four if suicides were included on the violent incident report forms.

2. The need to read narratives that frequently do not relate what occurred should be reduced by providing check boxes that would shorten both the reporting time and the reading time. Each category of incident should be broken down into its own varieties, i.e., there should be a check box for falls on the accidental injury

form; a check box for patient vs. employee on the assaultive incident form.

3. As the incidents almost always occur in one of several specific locations, there should be check boxes for these locations. The accidental injury form should contain check boxes for the patient's activity at the time of the accident, e.g., getting in or out of bed.

4. The specific time of the incident should be listed, but the form should also permit checking a box that would place the incident in one of six four-hour segments, thus permitting the department to determine the intensity of incident by time period.

5. In assaultive incident reporting, the names of all parties should be clearly discerible in spaces provided for that purpose at the top of the form.

Thus, simply by writing in names and checking boxes, the report reader can determine that patient Smith assaulted patient Jones in the day room. A space for injury description could reveal a two-inch cut above Jones' left eye. A space for cause could reveal that Smith punched Jones after he caught Jones sleeping in his bed.

6. One section of the report should identify the employees on the ward and indicate their participation in the incident.

7. As the overwhelming majority of incidents are given only cursory treatment by review committees, they should be given little space on the form and required to attach a separate report on the relatively few incidents they pursue.

8. Each ward should maintain a running record of people involved in assaultive incidents, thus permitting the institution to keep track of the activities of its most violent patients. It would require no more than writing three or four words, e.g., Smith punched Jones; Rollins kicked Brown; Smith and Brown fought. A director looking at a six-month list of such incidents, seeing that Smith was involved in 12 of the 18 incidents on the ward, would then be able to require as to what was being done to prevent Smith's assaultive activities.

9. The basic incident information—that provided by the check boxes, can be computerized. The department would be able to deal with frequencies and move to correct them. If the department were to learn, for example, that 49 per cent of all its falls occurred in the toilet, it might be surmised that the department would move to increase surveillance in its bathrooms.

10. Each institution should aggregate its data monthly for the director and regional director. Such aggregated information should be submitted at least semiannually to the central office.

Part IV

Board of Visitors

The committee and its chairman have been responsible, acting jointly with the Assembly Mental Health Committee, for amending 7.19 of the Mental Hygiene Law in 1975 and 1976 for the express purpose of expanding the powers of the Boards of Visitors and mandating their greater presence at state institutions.

The chairman, after the committee's review, not only of incident reports, but of Board of Visitors attendance records and of minutes of board meetings, is now convinced that serious questions exist as to the worth of continuing the boards as a monitor of conditions in mental institutions.

The board's principal function over the years has been to inspect hospitals they are supposed to monitor.

At their worst, they are social clubs whose members have accepted honorariums from the governor, not infrequently because of a political relationship. They gather bi-monthly to nod assent to the director's activities and explanations of conditions.

At their best, usually led by a minority of activist members, they challenge directors' decisions and the manner in which care and treatment are provided.

But at their best, unless they review all of the incident reports at their institutions, which few do, they are not aware of conditions at their hospitals.

A member of the Marcy board was asked at a December 3, 1976 committee hearing, how many incident reports had been filed in the month preceding the hearing. She replied that one had been filed. Marcy recorded 44 violent incidents a month in 1976, a figure that could be multiplied several times to arrive at the total number of incidents.

This particular board member had a manifest, documented interest in mental hygiene, which is now required for appointment to boards. The point is made not to single out the board member, but to suggest that it reflects a condition existent at many institutions.

If the director does not report the numbers of violent occurrences or medication errors or whatever else board members ought to be interested in, then board members cannot be expected to know the extent of these occurrences in their institutions—unless they ask, which would be based on the presumption that they are interested.

It is the committee's belief that the majority of boards in the state are not asking.

A review of the Marcy Board of Visitors minutes for the years 1973 through 1976 reveal no inquiries into conditions at the institution.

In those four years, the Marcy board manged a quorum at 18 of 37 meetings. Average attendance at seven 1975 meetings was 2.7 members. One member appointed in May 1976 attended his first three meetings, then missed the next three. One member attended an average 2.7 meetings a year during the four years.

Law requires a board to meet six times a year. Members may be excused from meetings by the president of the board.

Vacancies on boards clearly play a role in average attendance at board meetings. Buffalo averaged slightly more than 4 a meeting; Bronx, slightly more than five; Marcy, almost four in 1976, without weighting for vacancies.

Although board members do not receive statistical workups on ward by ward incidents, they do receive some indications of certain problems and identification of problem patients. The Buffalo director's report to the board has used hours of seclusion as a measurement of violence (one patient spent 265 hours in one month in seclusion).

The placidity noted in minutes of Marcy meetings has not aways been evident at either Bronx or Buffalo —at Bronx within the board itself and at Buffalo, in encounters with visiting antagonists.

Of the three, Bronx is the only one in which members tend to have an adversary relationship with the director at this time.

The Bronx board is now reviewing incident reports. Earlier minutes reflect an objection within the board to a delay in beginning the process.

Any board that does not review all incident reports is not doing its job. The only acceptable alternative is incident categorizations, honestly reported, that enable board members to grasp conditions in their institutions.

The committee presumes that, if board members knew that one ward reported twice as many patients falling as another ward with similar characteristics, at least one member would question why.

The boards that routinely accept director's reports without questioning might just as well not exist.

It is not sufficient to mandate that board members make added visits and improve attendance. Two hours a month and lunch with the director hardly provides the opportunity to size up conditions at any institution.

If we are to continue the Boards of Visitors, each member must understand his purpose, which essentially, is that of an adversary to the director.

The principal result of an unannounced visit is an assessment of cleanliness. In the 134 years since the first state mental institution opened at Utica, very few managers or visitors have observed a suicide, rape, patient assault, medication error or an escaping patient.

Cleanliness is indeed important. Pressure by the Bronx board produced a crash cleanup program. Conditions were so bad in some wards that it required the transfer of patients from these wards while "10 years" of dirt were removed.

Staffing limitations make the above-mentioned condition less pejorative. As an attendant told the chairman at Manhattan—"We've got so few people that we have the choice between cleaning patients or cleaning rooms."

Very few boards members are competent to question medical decisions. Historically, most of them are getting their first indoctrination into mental hygiene upon appointment to a board. That is changing, but board members are neither psychiatrists nor psychologists.

The board may report to the governor or to the commissioner at any time, and must make an annual "independent assessment of conditions" and report such to the governor. The committee submits that these provisions have had little impact on the care and treatment of residents in our mental facilities.

New law requires that board membership include "at least three individuals who are parents or relatives of patients or of former patients and that the remainder includes only those persons, including former patients, who shall express an active interest in, or shall have obtained professional knowledge in the care of the mentally disabled or in mental hygiene endeavors generally."

The intent is to appoint board members who know something about mental hygiene before they get there. However, two hours a month listening to a director and a now mandated twice-a-year inspection each year does not assure an accurate assessment of institution conditions.

Unless each director reports on all conditions present in his institution, and unless each board examines those reports thoroughly, the boards will not function adequately.

There are no indications whatsoever that this is taking place in the great majority of our institutions.

Each board if left to its own devices, and they have been insufficient to adequately monitor conditions in our psychiatric centers.

With much greater zeal than has been shown by the majority of boards, the Mental Health Information Service is now looking more and more into hospital conditions. To be sure, the MHIS staff is paid and board service is voluntary. But, at the same time, if a board member accepts an appointment with the understanding that some of his time must be devoted to scrutinizing hospital conditions, then the member should accept the responsibility or resign.

The committee concludes that if the boards continue to be left to their own devices to improve conditions in our hospitals, their purpose for existence will not be served.

COMMITTEE RECOMMENDATIONS:

1. An immediate assessment of the efficacy of boards of visitors as the monitor of conditions in mental institutions.

2. If the determination is that they have been ineffective, then either their role should be substantially enlarged and defined, or they should be eliminated in favor of another agency with greater ability to monitor hospital conditions.

3. If the boards are to continue, the members must have far greater orientation in the roles they are supposed to play, and a far greater understanding of the responsibilities that have been given them.

4. If the boards are to continue, members must demand much more information than they now receive about conditions in their hospitals.

5. If boards are to continue, then the practice of permitting board presidents to excuse absences should be discontinued, in favor of mandating attendance or inspection levels.

6. Boards should be made accountable. When institutions are publicly and legitimately criticized, boards should share the criticism.

When something goes wrong in an institution, the board should be asked what it did to prevent it. The board that demonstrates knowledge of an undesirable condition and an apathy toward correcting it, should be dismissed from further responsibility.

Visitors are placed in mental institutions to protect the interests of the people of the state and specifically, the patients in those institutions. They are not there to defend directors against criticism. They represent the people, not the department.

Part V

The Employee

The life of ward staff in a psychiatric center is not easy. It is one of the few occupations where the employee regularly faces the possibility of getting punched in the mouth by one of his or her clients, and at the same time, regularly must clean up after incontinent charges.

Compassion, patience and endurance are necessary qualifications for the job. The employee lacking any of these does not belong in a mental institution.

The committee believes that the majority of Department of Mental Hygiene employees are dedicated workers making sincere efforts to improve the lives of their clients.

However, there are exceptions and the department tries to weed them out through a disciplinary process that it considers weighted in favor of the employee.

The committee concurs with the department, and with the Mental Health Information Service, in their analyses of patient abuse procedures. The patient's interests are insufficiently represented at disciplinary hearings.

The committee believes, however, that although better representation for patients would improve the patient's opportunity for justice at such hearings, the problem will not be solved until arbitrators end their propensity for compromising.

An arbitrator sitting at a patient abuse hearing should not settle it as if it were a wage hearing, in which he could recommend 75 cents an hour as the compromise between an employer offering 50 cents and a union asking $1.

When the department seeks dismissal and the employee seeks full reinstatement, the answer is not always temporary suspension, on the apparent belief that that will make both sides happy.

The patient abuse arbitrator should understand that his role is not to please both sides, i.e., the department and the employee. The hearing is held to determin whether the employee has acted in the best interests of the patient, and, sometimes, whether thos actions suggest that the employee's further presence on the payroll is foreboding for the department's clients.

The present form and method of incident reporting does a disservice to both the department and the employee. It does not serve the department because there are few indications of the whereabouts of employees at the time of any incident.

It does not serve the employee in patient vs. employee encounters, particularly when restraint is attempted, because there is no mention of degree of difficulty. If two patients were injured undergoing restraint and one was an intercollegiate heavyweight wrestling champion and the other an adolescent, the incidents would be reported in the same way.

It stands to reason that the greater the physical specimen, the greater the battle attempting to restrain him, and thus, the greater the possibility of injury to both patient and employee.

This also suggests, that not only should the department be able to match its adversaries at disciplinary hearings, it should be able to match its disturbed patients on the wards.

The committee suggests, therefore, that size and strength are qualifications desirable in some mental hygiene employees. They are desirable not only in prevention and quelling of violent acts, but in the handling of falls.

Geriatrics patients fall more often than other patients. They must be picked up, a function that clearly requires strength.

At Buffalo, female employees represent 77.5 per cent of all ward staff. On the 4 p.m. to midnight shift, there are five wards with no male employees. From midnight to 8 a.m., there are four wards with no male employees. Only one of these wards is all-female.

Dr. Ralph Michener, the Buffalo director, testified at the committee's December 1st hearing in Buffalo that this was not a healthy situation.

The hospital, however, can only improve the ratio of male attendants and nurses if the Civil Service lists contain males who rank near the top of the lists. They do not. The lists are predominantly female.

The committee believes that the right of a patient to proper care and treatment is superior to the right of a person to hold a position taking care of the patient. The director who wants a 6-2, 180-pound employee on a ward to reduce violent behavior, hardly makes a healthy choice in sending a 5-5, 130-pound employee to fill that role. Size and strength, therefore, should be qualifications required of certain ward staff.

The committee questions, particularly when many department employees demonstrate concern about their futures because of the shift to community care, why their attendance records are not better. Bronx has expressed that concern and the committee's one-shot review of Buffalo attendance was alarming.

On the day shift at Buffalo on November 24th, 30.5 per cent of employees scheduled to work in medical-surgical/geriatrics were absent. In unitized service, 27 per cent were absent. Even for the day before Thanksgiving, those are extraordinarily high absentee rates and hardly manifest a dedication to service.

Dr. Michener testified that the hospital had been "talking with the union about trying to get a joint program to encourage employees to come to work as scheduled". The committee questions why employees who are reluctant to come to work are permitted to remain on the department payroll.

COMMITTEE RECOMMENDATIONS:

1. A continuing review of the disciplinary procedures to assure that patients' rights are protected.

2. Improvement in incident reporting so that employee participation is better established.

3. The hiring of enough ward staff with sufficient qualifications in size and strength to meet the needs of the patients, and to improve on their opportunities for safety.

4. A review of absenteeism within the department.

1. MARCY PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—1975

		No. of Patients			Patient vs. Patient				Patient vs. Employee			Emp. vs. Patient		Property Damage			Sex Assault	Total	Voluntary Sex	Fire	Suicide	Attempt. Suicide	Sudden Death	Medication Error	LWOC	Total
	Ward	M	F	Total	M/M	M/F	F/F	Total	M	F	Total	M	F	M	F	Total											
A	1			—																						
Bldg.	2			—			9	9	1		1				1	1		11								11
	3		23	23					1		1							1				3				4
	4	21		21	2			2										2								2
	5		25	25			4	4										4					1			5
	6	25		25	5			5										5								5
TOTAL		46	48	94	7		13	20	2		2				1	1		23				3	1			27
B	7		35	35			3	3										3								3
Bldg.	8	23		23	3			3										3						1		4
	9		24																					3		3
	10	21		21	7			7										7							3	10
	11		27	27			21	21										21						4	3	28
	12	25		25	13			13										13						1		14
	14	16		16	7		1	8	3		3			1		1		12							9	21
	15		38	38																				3		3
	16	22		22																				2		2
	17		22	22			8	8										8				4		3	10	24
	18	32		32	23			23										23						1	1	25
	19		33	33																				4		4
	20	12		12	3			3										3					1	2	1	7
	21		38	38			16	16										16					1	2		19
	22	29		29	4			4										4							4	8
	23		11	11																		1		9		10
	24	—	—	—	1			1	1		1							2								2
	25		31	31			19	19										19				2		2	6	29
	26	11		11	39			39	11		11	1						51				3				54
	27		19	19			27	27								1		28				7				35
TOTAL		191	278	469	100	0	95	195	15	0	15	1	0	1	1	2		213	0	0	0	17	2	36	37	305
C	30	—	—	—			1	1										1								1
Bldg.	31		48	48														0						1		1
	32		36	36			4	4										4						2		6
	33		45	45			4	4							1	1		5						2		7
	34		47	47			9	9										9					1		1	11
	35		49	49			13	13										13					1	1		15
TOTAL			225	225			31	31							1	1		32					2	6	1	41
D	40	—	—	—														0							1	1
Bldg.	41	33		33	1			1										1					1	1		3
	42	30		30	25			25	6		6			7		7		38					1	2	4	45
	43	36		36	11			11										11								11
	44	32		32	6			6	1		1			1		1		8					2		1	11
	45	38		38	14			14	1		1			2		2		17						1	2	20
TOTAL		160	—	169	57			57	8		8			10		10		75					2	4	8	91

2. MARCY PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—1975

		No. of Patients			Patient vs. Patient				Patient vs. Employee			Emp. vs. Patient		Property Damage			Sex Assault	Total	Voluntary Sex	Fire	Suicide	Attempt. Suicide	Sudden Death	Medication Error	LWOC	Total
	Ward	M	F	Total	M/M	M/F	F/F	Total	M	F	Total	M	F	M	F	Total											
E	50	5		5	16			16						2		2		18				1			5	24
Bldg.	51	20		20	5			5										5							1	6
	52		29	29			16	16										16						2		18
	53		32	32		1	1	2										2							1	3
	54	18		18	6			6	3		3			1		1		10						5	80	95
	55	20		20	9			9						3		3		12				2		1	1	16
	56		13	13			4	4							2	2		6				1		1	30	38
	57		22	22		1	8	9		1	1							10								10
TOTAL		63	96	159	36	2	29	67	3	1	4			6	2	8		79				4		9	118	210
F	60	18		18								1						1						2		3
Bldg.	61		13	13														0								0
	62		20	20	1		1	2										2								2
	63	23		23														0								0
	64		22	22			4	4										4							3	7
	65		32	32			21	21							1	1		22				1	1	2	2	28
	66	—	—	—			5	5										5				2		3	1	11
	67	26		26	1			1	1		1							2								2
TOTAL		67	87	154	2		31	33	1		1				1	1		36				3	1	7	6	53
G	70		39	39		2	2	4										4							2	6
Bldg.	71	26		26	2			2										2					1		2	5
	72		33	33			30	30		2	2							32				2			1	35
	73	18		18	3			3										3							2	5
	74	29		29	4			4										4								4
	75	29		29	9		1	10										10								10
	76	22		22	22			22	2		2	2		1		1		27						1	2	30
	77	17		17	2			2										2								2
TOTAL		141	72	213	42	2	33	77	2	2	4	2		1		1		84				2	1	1	9	97
Crane Hill School	80		11	11			24	24		1	1				1	1		26							7	33
	82	8		8	25			25										25								25
	83	12		12	22	1		23										23				1			6	30
	85		5	5														0						1	4	5
	86	7		7	2	2		4										4							33	37
TOTAL		27	16	43	49	3	24	76		1	1				1	1		78				1		1	50	130

3. MARCY PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—1975

	Ward	No. of Patients M	F	Total	Patient vs. Patient M/M	M/F	F/F	Total	Patient vs. Employee M	F	Total	Emp. vs. Patient M	F	Property Damage M	F	Total	Sex Assault	Total	Voluntary Sex	Fire	Suicide	Attempt. Suicide	Sudden Death	Medication Error	LWOC	Total
Unit	A	46	48	94	7		13	20	2		2			1	1			23				3	1			27
	B	191	278	469	100		95	195	15		15	1		1	1	2		213				17	2	36	37	305
	C		225	225			31	31						1	1			32					2	6	1	41
	D	169		169	57			57	8		8			10		10		75					2	4	8	89
	E	63	96	159	36	2	29	67	3	1	4			6	2	8		79				4		9	118	210
	F	67	87	154	2		31	33	1		1	1			1	1		36				3	1	7	6	53
	G	141	72	213	42	2	33	77	2	2	4	2		1		1		84				2	1	1	9	97
	CH	27	16	43	49	3	24	76		1	1				1	1		78				1		1	50	130
TOTAL MARCY		704	822	1526	293	7	256	556	31	4	35	4		18	7	25	0	620	0	0	0	30	9	64	229	952

4. MARCY PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—By Month

		Jan	Feb	Mar	Ap	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Assaultive Incidents	1975	41	50	73	53	57	60	39	38	48	62	59	37	620*
	1976	49	33	61	59	58	29	38	40	54	21	—	—	441
Total		90	83	134	112	115	89	76	78	102	83	(59)	(37)	1061*
Attempted Suicides	1975	3	2	2	1	4	1	1	8	2	2	3	1	30
	1976	2	2	—	3	2	3	8	9	3	2	—	—	34
Total		5	4	2	4	6	4	9	17	5	4	(3)	(1)	64
Sudden Deaths	1975	1	2	—	—	1	—	2	2	2	—	1	—	11
	1976	3	—	2	1	1	—	—	1	1	—	—	—	9
Total		4	2	2	1	2	—	2	3	3	—	(1)	(—)	20
Medication Errors	1975	2	8	7	2	8	11	5	2	3	12	2	2	64
	1976	8	3	2	5	4	3	1	8	0	3	—	—	37
Total		10	11	9	7	12	14	6	10	3	15	(2)	(2)	101
Leaves W.O. Consent	1975	10	5	13	34	21	25	13	36	19	28	12	13	229
	1976	5	9	9	9	19	19	6	17	18	5	—	—	116
Total		15	14	22	43	40	44	19	53	37	33	(12)	(13)	345

	1975-76	Jan	Feb	Mar	Ap	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Assaultive Incidents		90	83	134	112	115	89	76	78	102	83	(59)	(37)	1061*
Attempted Suicides		5	4	2	4	6	4	9	17	5	4	(3)	(1)	64
Sudden Deaths		4	2	2	1	2	—	2	3	3	—	(1)	(—)	20
Medication Errors		10	11	9	7	12	14	6	10	3	15	(2)	(2)	101
Leaves W.O. Consent		15	14	22	43	40	44	19	53	37	33	(12)	(13)	345
Total		124	114	169	167	175	151	112	161	150	135	(77)	(53)	1591*

* Includes 3 Unclassified.

1. BUFFALO PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—1975

	Ward	No. of Patients M	F	Total	Patient vs. Patient M/M	M/F	F/F	Total	Patient vs. Employee M	F	Total	Emp. vs. Patient M	F	Property Damage M	F	Total	Sex Assault	Total	Voluntary Sex	Fire	Suicide	Attempt. Suicide	Sudden Death	Medication Error	LWOC	Total
Unit IV	67				2		1	3	2	1	3					2	1	9	1	1	1	3			9	24
	77																	0							2	2
	62/72																									
TOTAL					2		1	3	2	1	3					2	1	9	1	1	1	3			11	26
Niagara Unit	63									1	1							1							1	2
	73				1	1	1	3								1		4				1			1	6
	64				1			1										1								1
	74				1		1	2										2								2
TOTAL					3	1	2	6		1	1					1		8				1			2	11
South Unit	68				9			9										9			1	1	1			12
	78						5	5										5	1		4					10
	62				8	3	5	16	2		2					1		19								19
	72				9	3	2	14	5	1	6							20	1		3				14	44
	65																									
	66				2			2										2								2
TOTAL					28	6	12	46	7	1	8					1		55	1	1	1	8	1		14	81
North Unit	80				11	5		16	3	1	4					1		21		5		3			27	56
	83				2	3	3	8		2	2						1	11		1		1	1		5	19
	81						13	13		3	3					1		17							9	26
	84				13			13	4		4					2		19							25	44
	67/77																									
TOTAL					26	8	16	50	7	6	13					4	1	68	0	6	0	4	1		66	145
Units Total		193	160	353	59	15	31	105	16	9	25	0	0			8	2	140	2	8	2	16			93	263
Unclassified								2			47							49						6		55
Unitized Total		193	160	353	59	15	31	107	16	9	72	0	0	0	0	8	2	189	2	8	2	16	2	6	93	318
Med. Surg.	40																	0							1	1
	41																	0				1				1
TOTAL																		0				1			1	2

2. BUFFALO PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—1975

		No. of Patients			Patient vs. Patient				Patient vs. Employee			Emp. vs. Patient		Property Damage			Sex Assault	Total	Voluntary Sex	Fire	Suicide	Attempt. Suicide	Sudden Death	Medication Error	LWOC	Total
	Ward	M	F	Total	M/M	M/F	F/F	Total	M	F	Total	M	F	M	F	Total											
Geri-atrics	42					1		1	1		1							2	1								3
	44				2		1	3										3									3
	45					1	1	2										2						4			6
	46																	0									0
	47				1			1										1						4			5
	48						2	2										2						2			4
	49					2	2	4										4						4			8
	50						3	3		1	1							4						3	1		8
	51				4			4	2		2					1		7						2	1		10
TOTAL					7	4	9	20	3	1	4					1		25	1					19	2		47
Ger. Adms.	52				1		1	2	1		1					1		4						1	1		6
	53				1	1	8	10										10						3			13
	55						1	1										1				1		1			3
TOTAL					2	1	10	13	1		1					1		15				1		6	1		22
TOTAL		115	198	313	9	5	19	33	4	1	5					2		40	1			2		24	4		71
Uniclass-fied								8			13					0		21									21
M.S./ Ger.					9	5	19	41	4	1	18					2		61	1			2		24	4		92
Total		115	198	313																							
Other	—	—	—	—	4	3	3	10	3	5	8						1	19	1		1	2					23
Unclassi-fied								7			7					1		15						6			15
Total					4	3	3	17	3	5	15	0	0			1	1	34	1	0	1	2		30			38

3. BUFFALO PSYCHIATRIC CENTER—Assaultive and Other Selected Incidents—1975

Ward	No. of Patients			Patient vs. Patient				Patient vs. Employee			Emp. vs. Patient		Property Damage			Sex Assault	Total	Voluntary Sex	Fire	Suicide	Attempt. Suicide	Sudden Death	Medication Error	LWOC	Total
	M	F	Total	M/M	M/F	F/F	Total	M	F	Total	M	F	M	F	Total										
Unit IV				2		1	3	2	1	3					2	1	9	1	1	1	3			11	26
Niagara				3	1	2	6		1	1					1		8				1			2	11
South				28	6	12	46	7	1	8					1		55	1	1	1	8	1		14	81
North				26	8	16	50	7	6	13					4	1	68		6		4	1		66	145
Unclassified							2			47							49						6		55
Total	193	160	353	59	15	31	107	16	9	72					8	2	189	2	8	2	16	2	6	93	318
Med.-Sur.																					1			1	2
Geri.				7	4	9	20	3	1	4					1		25	1					19	2	47
Ger. Adm.				2	1	10	13	1		1					1		15				1		5	1	22
Unclassified							8			13							21								21
Total	115	198	313	9	5	19	41	4	1	18					2	0	61	1	0	0	2	0	24	4	92
Other				4	3	3	10	3	5	8						1	19	1	0	1	2	3			26
Unclassified							7			7					1		15								15
Total	—	—	—	4	3	3	17	3	5	15					1	1	34	1	0	1	2	3			41
Unclassified	193	160	353	59	15	31	107	16	9	72					8	2	189	2	8	2	16	2	6	93	316
M.S./ Ger.	115	198	313	9	5	19	41	4	1	18					2	0	61	1	0	0	2	0	24	4	92
Other	—	—	—	4	3	3	17	3	5	15					1	1	34	1	0	1	2	3		0	38
Total	308	358	666	72	23	53	165	23	15	105	0	0			11	3	284	4	8	3	20	5	30	97	451

FORM 147 DMH (2/72)

N. Y. STATE DEPT. OF MENTAL HYGIENE

INCIDENT REPORT

- Notify physician immediately.
- Ward Charge - Fill in Part 1 in duplicate.
- Physician - Fill in Part 2 and submit original to Special Review Committee.
- File COPY II on ward.
- Special Review Committee - Fill in Part 3.

PART 1 - *Please Print*

1. PATIENT'S NAME (LAST, FIRST, M.I.)	2. SEX [M] [F]	3. CONSECUTIVE NO.
4. MENTAL DIAGNOSIS	5. WARD	6. FACILITY NAME

5. PLACE OF INCIDENT	8. DATE OF INCIDENT MO. / DAY / YR.	9. TIME OF INCIDENT	10. WAS EMPLOYEE INVOLVED? YES [ ] NO [ ]
	/ /		

11. INCIDENT CLASSIFICATION

- [A] Suicide (or attempt)
- [B] Sudden death
- [C] Accidental death
- [D] Homicide (or attempt)
- [E] Assault
- [F] Patient fight
- [G] Accidental Injury
- [H] Work related injury
- [I] Serious drug reaction
- [J] Medication error
- [K] Other _____
- [L] Abuse of child, resident or patient
- [M] Leave without consent [report "escape" in this category] YES [ ] NO [ ]

Alien or Non-Resident?

12. DESCRIBE EVENT: Include injuries, first aid given, employee involvement. Attach separate statements of witnesses or participants.

Physician notified immediately? YES [ ] NO [ ] Name of doctor:

Sample
Present DMH Form

SIGNATURE OF WARD CHARGE DATE TIME

PART 2 - PHYSICIAN'S FINDINGS AND TREATMENT ORDERED: Referred to X-Ray YES [ ] NO [ ]

SIGNATURE OF PHYSICIAN DATE TIME

PART 3 - SPECIAL REVIEW COMMITTEE: Include findings, autopsy review, recommendations, corrective action taken, names of people (or committee) notified.

- Notify Central Office if (a) alien or non-resident is on Leave Without Consent (b) case is unusual.
- File xerox copy in (a) patient/resident folder (b) employee personnel folder if employee was involved.
- File ORIGINAL in Special Review Committee file in Consecutive Number Order, by year.

DATE SUBMITTED TO DIRECTOR	SIGNATURE FOR SPECIAL REVIEW COMMITTEE	DIRECTOR'S SIGNATURE APPROVED	CENTRAL OFFICE NOTIFIED? YES [ ] NO [ ]

Form 147 DMH (2-77)

New York State Department of Mental Hygiene

INCIDENT REPORT

1. Incident Number

File Copy 1 – Ward, 2 – Patient's Record, 3 – Deputy Director

Section 1 – To be Completed by Person with First Knowledge of Incident.

2. Facility Name — Code

3. Client's Name (Last, First) Print

4. Consecutive No.

5. Age

6. Date of Incident — MO Day YR

7. Time of Incident — 1. ☐ Occurred 2. ☐ Found — HR MIN — AM ☐ PM ☐

8. Was Incident Witnessed? 1. ☐ Yes 2. ☐ No

9. Names of Witnesses (Indicate whether witness was an Employee, Visitor, or Client by circling E, V, or C.)

1. _____ E V C

2. _____ E V C

10. Client Bldg. No.

11. Client's Ward No.

12. Census of Client's Ward

13. Employees on Duty on Client's Ward

14. Was Another Client Involved? 1. ☐ Yes 2. ☐ No

15. Was an Employee Involved? 1. ☐ Yes 2. ☐ No

16. Type of Incident (Check one)

1. ☐ Injury
2. ☐ Elopement
3. ☐ Drug Reaction
4. ☐ Suicide Attempt
5. ☐ Suspected Suicide
6. ☐ Death (Not Suicide)
7. ☐ Other _____

17. Location Where Incident Occurred (Check one)

a. ☐ Ward/Room
b. ☐ Ward/Sleeping Area
c. ☐ Dining Room
d. ☐ Hallway
e. ☐ Kitchen
f. ☐ Staircase
g. ☐ Shower/Bathroom
h. ☐ Recreation Area
i. ☐ Program Area
j. ☐ Off Facility Property
k. ☐ Unknown
l. ☐ Other

18. Date and Time Physician was Notified — MO Day YR — HR MIN — AM ☐ PM ☐

19. Incident Occurred: (Check one) 1. ☐ Indoors 2. ☐ Outdoors

At Bldg. # ☐☐☐

At Ward # ☐☐☐

20. Description of Incident (Include injuries, first aid given, employee involvement and other client involvement.)

Sample Proposed form DMH - Page 1

Name of Person Completing This Section (Print) _____ Date: _____

Title _____ Signature _____

SECTION 2 To be Completed by Examining Physician.

21. Type of Injury (Check all which apply)

☐ None Sustained
☐ Superficial
☐ Bruise
☐ Bite
☐ Swelling
☐ Discoloration
☐ Laceration
☐ Burn
☐ Possible Fracture
☐ Dislocation
☐ Sprain
☐ Other Injury _____

22. Disposition (Check all which apply)

☐ No Further Treatment
☐ Modified Medication
☐ Treatment Plan Modified
☐ Referred to X-Ray
☐ Transferred to Medical Unit
☐ Referred for Consultation
☐ Referred to Med. Examiner
☐ Other _____

23. Statement of Treated Client. (Print)

Is Client's Statement Reliable? 1. ☐ Yes 2. ☐ No

24. Description (Treatment and findings) If medication is modified, specify previous and new medications. (Print)

Date of Examination — MO Day YR

Time — HR MIN — AM ☐ PM ☐

Appropriate Notifications should be made: family, police, administrators, etc.

Physician Name _____ (print)

Signature _____

Form 147 DMH (2-77) page 2

Section 3: To Be Completed by Investigator Designated According to Facility Policy

25. Date and Time Team Leader was Notified
MO Day YR HR MIN AM ☐ PM ☐

26. Classification of Incident (Check one)
1. ☐ Assault
2. ☐ Self Abuse
3. ☐ Accident
4. ☐ Unknown
5. ☐ Other _____

27. Causes of Incident (Check all which apply)
☐ Behavior of Injured Client
☐ Behavior of other Client
☐ Injured Client's Physical Infirmity, Illness or Seizure
☐ Injured Client's Intoxication or Drug Misuse
☐ Medication Error re Injured Client
☐ Actions of an Employee
☐ Hazardous conditions in Building or on Facility property
☐ Faulty, Inadequate or Inappropriate Equipment
☐ Recreational Activity
☐ None
☐ Unknown
☐ Other _____

28. Notifications Made (Check all which apply)
☐ None
☐ Police
☐ Family/Guardian
☐ Mental Health Information Service (MHIS)
☐ Other

29. Actions Taken (Check all which apply)
☐ Modified Injured Client's Medication/Treatment Plan
☐ Staff Redeployed
☐ Injured Client Moved to Another Location
☐ Employee Disciplinary/Corrective Action Taken
☐ Hazardous Conditions Corrected
☐ Equipment Replaced or Repaired
☐ Further Investigation Recommended
☐ No Action Taken
☐ Other _____

30.0 Complete This Section if Another Client Caused Incident

30.1 Name (Last, First) Print

30.2 Consecutive Number

30.3 Actions Taken for Client who Caused Incident (Check all which apply)
☐ Moved this Client
☐ Modified Medication/Treatment Plan
☐ No Action Taken
☐ Other _____

30.4 This Client Caused Incident: (Check one)
1. ☐ Accidentally
2. ☐ Deliberately
3. ☐ Unknown

30.5 Was an Incident Report Completed for this Client
1. ☐ Yes
2. ☐ No

31.0 Complete This Section if an Escape or Leave Without Consent Case:

31.1 Residency: (Check all which apply)
☐ Alien
☐ New York State Resident

31.2 Legal Status (Check one)
☐ Voluntary
☐ Involuntary

31.3 Actions Taken (Check all which apply)
☐ Client Located and Returned
☐ Client Discharged
☐ Client Not Found
☐ Other _____

32. Report (Review Sections 1 and 2 of form to determine if all required information is included.) Make additional comments if appropriate.

Sample Proposed Form DMH - Page 2

Date _____ Appropriate Notifications should be made: family, police, administrators, etc.

Name of Person Completing This Section (Print) _____

Title _____

Signature _____

Section 4: To Be Completed by Review Committee

33. Has this Committee changed any of the conclusions drawn in Section 3?
1. ☐ Yes
2. ☐ No

34. Is this a Case of Employee Abuse, Mistreatment or Neglect?
1. ☐ Yes
2. ☐ No

If yes, notify Regional Office

35. Actions Taken by this Committee (Check all which apply)
☐ Facility Practice/Procedure Reviewed
☐ Employee Disciplinary/Corrective Action Recommended
☐ Other _____

36. Notifications made by the Committee (Check all which apply)
☐ Board of Visitors
☐ Professional Advisory Board
☐ Consumer Advisory Board
☐ Immigration Office
☐ Child Abuse Registry
☐ Other _____

37. Comments (Print)

Name of Person Completing This Section (Print) _____ Title _____ Date _____

Director _____ Date _____
Signature

NYS DMH

Patients Name

Consecutive No. Age Sex M☐ F☐

Home Ward Unit Facility

Mental Diagnosis

ACCIDENTAL INCIDENT
- ☐ Choking on Food
- ☐ Sudden Death
- ☐ Accidental Death
- ☐ Fall
- ☐ Other
- ☐ Unknown

Incident Date: / / Time: Unknown

Incident Discovered/Reported: Date: / / Time:

Time Period Of Incident: 8AM-12 ☐ 12-4 ☐ 4-8 ☐ 8-12Mid ☐ 12-4 ☐ 4-8AM ☐

LOCATION:
- ☐ Off Grounds
- ☐ Bedroom
- ☐ Toilet
- ☐ Shower
- ☐ Day Room
- ☐ Hallway
- ☐ Stairs
- ☐ Dining Room
- ☐ Other Ward No. ___
- ☐ Other _____
- ☐ Unknown

WHILE PATIENT WAS:
- ☐ Sleeping
- ☐ Getting in/out of bed
- ☐ Dressing/Undressing
- ☐ Walking
- ☐ Eating
- ☐ In Wheelchair
- ☐ Getting in/out of chair
- ☐ In the Toilet
- ☐ Other
- ☐ Unknown

DESCRIBE INJURY:

Sample Proposed Form Select Committee

CAUSE OF INJURY/INCIDENT:

	Employee(s) Names	Employees on Ward/Attending at time of incident	At Time of incident, Nearest employees were:
Reported to			
Heard by			Location:
Discovered by			Activity:
Witnessed by		☐ Unknown	☐ Unknown

Physician Notified Immediately ☐ Yes ☐ No Dr. _____

Signature of Ward Charge / / Date : Time

PHYSICIAN'S FINDINGS + TREATMENTS ORDERED

REFERRED TO X-RAY ☐ Yes ☐ No

Signature of Physician / / Date : Time

Special Review Committee

☐ No Further Action ☐ See Attached

Signature for Committee / / Date : Time

Date Submitted To Director / /

Director's Signature

Central Office Notified ☐ Yes ☐ No

Was Other Incident Report filed that relates to this incident ☐ Yes ☐ No