Psychiatric Emergency Room Overcrowding: A Case Study

NYS Commission on
QUALITY
OF CARE
for the Mentally Disabled

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Executive Summary

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

The persistent problems associated with the organization of psychiatric emergency rooms (PERs) and inpatient units in municipal hospitals in New York City as illustrated by this case have caused incalculable suffering for patients and their families and have frustrated and disheartened hospital staff members who attempt to deliver careful and considered psychiatric treatment. In an effort to deal with the demand for psychiatric inpatient beds, that far exceeds the supply, diversion procedures and "tripwire" agreements are implemented and result in the transfer of psychiatric patients from emergency rooms of New York City municipal hospitals to other psychiatric facilities where there are vacant beds. Diversion procedures also allow patients, such as Armando Peteros, to be legally admitted to a hospital, held in the emergency room for up to 72 hours until a bed becomes available some place in the system, and then transferred to another facility.

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

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

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

* A pseudonym.

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

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

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

1. The phase-out of the "tripwire" and diversion procedures as soon as possible. In order to facilitate this goal, the Commission recommends that OMH provide substantial technical assistance to HHC hospitals to ensure that patients who no longer require acute care are placed in more appropriate settings. At the same time, HHC facilities need to examine their own staffing needs to better comply with the requirements of sound clinical practice, as well as state laws, governing discharge planning.
2. Support of both the OMH plan to expand community residence beds over the next ten years to accommodate an additional 16,000 persons and the OMH intensive case management initiative. In addition, OMH should assure, on a regional basis, the capacity of outpatient programs to provide extended hour clinic services, crisis services both on site and through mobile units, family and in-home support and meaningful follow-up, including home visits to patients who fail to keep appointments and who are likely to decompensate.
3. The Department of Health, in consultation with OMH, should develop specific standards for psychiatric emergency rooms which include staffing standards. The requirement that each PER develop a consistently dependable system for in-house record retrieval also should be included in the operating standards.
4. Following an inpatient psychiatric stay, a summary of treatment should be sent to the provider of outpatient clinical services and the case manager. Similarly, when patients are treated in PERs and released, this information should be communicated to the outpatient service provider and case manager. Outpatient clinics must assume respon-

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

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

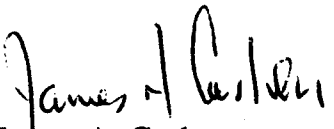
5. OMH and the HHC should develop with the NYC Police Department a protocol to ensure that hospital personnel can secure specific detailed information from police officers about the circumstances under which a patient is brought to the PER. This might include a procedure whereby clinicians can get this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

As indicated above, this Commission report and its recommendations already have elicited positive responses from OMH and HHC, as well as from the State Health Department and the New York City Department of Mental Health, Mental Retardation and Alcoholism Services, all of which are appended. All parties agree that, while tripwire arrangements have been a necessary safety valve in relieving emergency room overcrowding, alternative measures must be found. To this end, OMH is preparing a position paper outlining alternatives to the existing system and possible assumption by OMH of more responsibility for the care of patients requiring longer lengths of stay, in exchange for a reduced role in providing acute psychiatric care in New York City. Negotiations between OMH and HHC around this issue have begun. In addition, OMH notes that it is in the process of reviewing outpatient programs to assess their adequacy in meeting the needs of the seriously and persistently mentally ill.* OMH also has reviewed the status of psychiatric emergency services in municipal State hospitals in New York City and has developed both short-term strategies to alleviate the overcrowding and a multi-year plan, including a comprehensive legislative proposal, to restructure emergency services. This proposal, highlighted in the Governor's 1989 Message to the Legislature, would return PERs to their proper use. A second plan for the establishment of Supported Housing would provide rent subsidies to assure that persons with mental illness will have access to available housing.

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

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

Clarence J. Sundram
Chairman



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

Acknowledgements

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

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Introduction

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

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

Background

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

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

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

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

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

November 11, 1987

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

At 6:30 a.m. the next morning, after receiving medical clearance, Mr. Peteros was admitted to Kings County Hospital Psychiatric Emergency Room. He was medicated, placed on 1:1 assaultive watch and confined to the holding area, because there were no inpatient psychiatric beds available. While the Kings County Hospital Psychiatric Emergency Room notes relate Mr. Peteros's violence toward the police, they make no mention of the cause of the police call, namely, violence toward his parents. Although the psychiatric emergency room staff made attempts to contact Mr. Peteros's parents, they were not successful.

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

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

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

November 12--December 2, 1987

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

Mr. Peteros's CSS case worker saw him once during his screening on November 19, 1987 while he was an inpatient at Kingsboro Psychiatric Center. The next attempted contact with the patient was on December 30, 1987, when she called the ward and was informed that Mr. Peteros had been discharged.

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

December 9--December 22, 1987

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

December 26--December 28, 1987

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

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

February 13-15, Presidents' Weekend

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

Fifteen hours after first appearing at the Maimonides Medical Center, Mr. Peteros was again brought by police to Maimonides on February 14, 1988 at 4:00 p.m., after calling the police and again claiming to have chopped up a woman. The nurses' triage notes at the hospital confirmed that Mr. Peteros was convinced he had "hacked up" a popular singer and "put her pieces in New Jersey". The notes also stated that the patient had attacked police when they attempted to bring him to the hospital. During the middle of the night, Mr. Peteros was transferred to Kings County Hospital, and admitted at 3:45 a.m. on Monday of Presidents' Weekend (February 15) to the psychiatric emergency room holding area on diversion status as a voluntary patient. Again, Kings County Hospital staff failed to secure a copy of his November 11 psychiatric emergency room record or his December 26 record.

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

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

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

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

Conditions in the Kings County Hospital Psychiatric Emergency Room over President's Weekend were even more stressful than on November 12, 1987. The psychiatric emergency room was very crowded; there were 12 patients on diversion, bringing the psychiatric service patient census to 174; the service was instituting a process for weekend evaluations of patients on diversion status. These evaluations would determine whether there were reasons to rescind any admission decisions because of changes in patients' clinical status.

February 26, 1988

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

Discussion

The Impact of Overcrowding

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

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

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

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

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

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

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

Neither is it the point to absolve the failures of the physicians and other staff members as inevitable given the enormity of the burden and their lack of resources. Critiquing his own failure to document his work, one physician used the word "terrible," an apt description of a number of documentation omissions by physicians in this case. Such omissions are more than just technical failures to comply with paperwork requirements. They effectively deprived all other clinicians, who made decisions about the care of this patient, of access to important and relevant information.

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

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

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

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

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

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

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

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

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