

**A Review of the New York State Office of
Alcoholism and Substance Abuse Services’
Addiction Treatment Centers**

**New York State Commission on Quality of Care and Advocacy
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Executive Summary

At the request of the Commissioner of the Office of Alcoholism and Substance Abuse Services (OASAS), the Commission undertook a review of conditions and selected polices of the 13 state operated Addiction Treatment Centers (ATCs). Specifically, the OASAS Commissioner was interested in an objective assessment of the consistency of services and conditions among the different centers. This review was conducted in 2004.

It is the rare agency that invites an oversight body to critically examine its operations. OASAS did just that, opening ATC doors to Commission reviewers who arrived unannounced over a several month period; allowing unfettered access to staff and patients for private interviews; and promptly producing any record and policy requested. That OASAS invited such review is a testament to its quest for excellence.

This report presents the Commission's findings as gleaned through unannounced site visits, interviews with ATC patients and staff, record reviews, and comparisons of OASAS regulations and policies and those of the individual ATCs.

This document is intended to offer guidance to OASAS as it endeavors to promote better or best practices and ensure consistency in addiction treatment services to individuals across the state. The report is necessarily detailed, describing findings across facilities in each issue area assessed.

Arising from the detail, however, are several overarching themes.

First, overall the ATCs offered clean, well-maintained, and comfortable treatment environments. During unannounced site visits, Commission staff found programming occurring as scheduled.

Second, the patients interviewed spoke highly of their care at the ATCs. When asked what they found most helpful in their treatment, the top three categories of responses were: the staff, programming, and peer support. All the patients, save one, indicated that they felt safe in their ATCs.

Third, in reviewing events that could adversely impact on patient health and safety, the Commission found that most were duly reported and managed as incidents consistent with OASAS policies.

Fourth, the policies of individual facilities on topics including admission and discharge practices, incident management, psychiatric and medical emergencies, and patient rights were generally consistent. The Commission was very impressed with the patient handbooks given to patients at each ATC at the time of their admission, orienting them to the facility, the treatment process, their rights and responsibilities, and the grievance processes, should they have any concerns.

Fifth, there are some areas in which OASAS can devote attention to ensure best practices and consistency in service across the ATC system. Some ATCs were not accessible to individuals

with physical disabilities, as detailed in the report. However, in every case, agreements exist to admit individuals with mobility impairments to another ATC that is fully accessible. While programming was occurring as scheduled at all the ATCs, program offerings and intensity varied. As OASAS explores this matter further, through patient satisfaction surveys, they may also want to seek the input of patients who had opinions on programming. Although the vast majority of ATC staff felt safe, a small number of staff indicated that they did not feel safe within the ATCs, some citing the increasing number of patients with mental illness and/or behavioral difficulties. There also appeared to be variations among the facilities on how they manage discharges against clinical advice (ACA), with some treating the event as an incident and examining the reasons why patients left, and others not. Understanding why patients leave treatment may help prevent such departures. Finally, in each of the policy areas examined, better or best practices emerged at different ATCs which may be worthy of replication statewide. As detailed in the report, these items ranged from who should accompany patients to hospitals in psychiatric/medical emergencies to documentation practices surrounding discharge planning and follow up.

The Commission hopes that this report is of assistance to OASAS in its quest and we thank all OASAS senior personnel and facility managers, staff and patients who participated and assisted in this review.

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Introduction

In 2004, at the invitation of the Commissioner of the New York State Office of Alcoholism and Substance Abuse Services (OASAS), the Commission conducted a review of the OASAS operated Addiction Treatment Centers (ATCs). There are 13 ATCs located throughout New York State. Each ATC provides an inpatient level of care to individuals in need of chemical dependency services.

The OASAS Commissioner expressed the desire for an independent and objective assessment of the ATCs with a particular interest in consistency among the individual ATCs. Each ATC has its own administration as well as individual policies governing its own particular operation and population that it serves. (See Appendix A for a list of the ATCs and their catchment areas).

After consulting with senior OASAS staff, the Commission designed a review protocol, which included unannounced site visits, patient and staff interviews, and reviews of incident reporting and various facility policies. The review was designed to evaluate the following issues: environmental conditions, programming and activities, patient and staff perspective on services, incident management, and consistency among key ATC policies.

During the spring and summer of 2004, teams of Commission staff conducted unannounced site visits to each of the 13 ATCs. During these site visits, environmental conditions were assessed, programming schedules were reviewed, and over 200 patients and staff were interviewed. In addition, Commission staff examined ATC communication logs to determine what kinds of incidents may be occurring at the ATCs and how these incidents were handled. Finally, while off-site, Commission staff reviewed and compared each ATC's policies on admission, discharge, workplace violence, the management of medical and psychiatric emergencies, and patient rights.

In late 2004 and early 2005, the Commission briefed senior OASAS staff and individual ATC directors on the findings of this review. During the briefings, discussions focused on uniquely positive practices, practices worthy of replication at other ATCs, and areas in need of improvement.

This report represents the Commission's 2004 findings. Since this time, the Commission has, through the briefing process, become aware of additional information that responds to some of the observations noted in this report. This information is reflected in footnotes.

Environment

All but two of the ATCs are located in a building on the grounds of a psychiatric center operated by the New York State Office of Mental Health (OMH). While OMH is technically the “landlord,” OASAS is responsible for housekeeping, general maintenance of the building (or the space that OASAS occupies in the building), and any capital costs.

During unannounced site visits, Commission staff toured each ATC, concentrating on patient bedrooms, bathrooms, laundry areas, activity and common areas, and dining areas and meals.

Bedrooms

Most ATCs had bedrooms that were clean and in good repair. There was adequate furniture, bedding, clothing, and personal storage space. Bedrooms at Norris, CK Post, and Richard Ward contained humanizing effects such as framed prints on the walls, curtains, and bulletin boards for patients to hang personal effects. In addition, bedrooms at McPike had locked armoires for each patient to secure personal belongings.

There were also some areas of concern noted. Several ATCs did not have bedrooms that were accessible to people with physical disabilities. For example, bedrooms at Creedmoor were very small with some rooms having only 2-2 ½ feet between beds. Bedrooms at Van Dyke were not accessible. However, both Creedmoor and VanDyke may transfer patients to other ATCs in close proximity that are fully accessible.

At the time of the Commission’s site visits, a few of the ATCs (Stutzman and St. Lawrence, for example) had no air conditioning in either all or part of the facility¹. While room temperature was not an issue during the Commission’s site visits, both patients and staff commented on problems with heat during the summer months.

Finally, several ATCs had bedrooms that were in need of repair. Bronx, Creedmoor, and South Beach had some bedrooms with missing screens, missing shades, and broken window knobs. In addition, CK Post, Kingsboro, and South Beach had rooms with cracked or lumpy mattresses, dirty window shades, and missing or broken lampshades. These issues either have been or will be addressed in current capital projects.

Bathrooms

Commission staff found an adequate number of bathrooms in each ATC with adequate supplies of soap, paper towels, and toilet paper. Most equipment was in working order and bathrooms were generally clean.

There were also some areas of concern. Van Dyke and Creedmoor did not have bathrooms that were accessible to patients with physical disabilities. However, as

¹ Seven ATCs have air conditioning

previously noted, there are agreements to transfer patients requiring accessible facilities to other ATCs that are fully accessible. Bronx and Manhattan had problems with hot water. Specifically, some sinks at Bronx ATC took several minutes to get hot water. At Manhattan, there was one cold shower in the women's bathroom and tepid water in the women's sinks. Finally, at least one bathroom at McPike, South Beach, Bronx, Manhattan, and St. Lawrence was in need of minor repairs (such as replacing missing tiles and caulking) and/or a thorough cleaning. The Commission was pleased to learn that many of these issues have been, or are in the process of being addressed. For example, an auxiliary hot water booster is included in Bronx ATC's next capital project.

Laundry

Patients do their own laundry and all of the ATCs had washers and dryers that were clean and in working order. Clean linens are provided at least once a week. The Commission's review noted that CK Post and South Beach had spare washing machines in case one was to break down. Finally, several ATCs provided patients with additional amenities such as soap, ironing boards, and dryer sheets.

Activity and Common Areas

Most ATC activity and common areas were clean and well decorated with adequate space and seating. In addition, most ATCs had separate activity and common areas for men and women. Several ATCs had specialized activity areas. For example, Manhattan and Norris had a craft room, McPike had an exercise room with innovative therapeutic activities, and Bronx had a library with books and two computers. Accessibility for patients with physical disabilities was again an issue, with Creedmoor and Van Dyke having activity and common areas that were not accessible and/or barrier free.

While touring activity and common areas, Commission staff looked for items that would keep patients connected with the outside world (e.g., TVs, newspapers, calendars, pay phones). With the exception of CK Post, these items were available. CK Post does not allow newspapers for clinical reasons. In addition, CK Post does not have pay phones.

All ATCs allowed patients to smoke outside with the exception of Manhattan, Norris, Stutzman, and Van Dyke who do not allow smoking anywhere on their grounds. Since the Commission's site visits, South Beach, Creedmoor, CK Post, and Kingsboro have also gone smoke-free. OASAS has determined that all ATCs will be integrating the treatment of nicotine dependence into their programming and that all ATCs will be smoke free by the end of March 2006.

Dining Areas and Meals

As part of the review protocol, Commission staff observed a meal served at each of the ATCs. In general, dining areas were clean, well-ventilated and odor-free. In addition, a few ATCs (such as CK Post, Richard Ward, and Manhattan) provided humanizing touches such as tablecloths and silverware.

Meals were served cafeteria-style and seating arrangements varied. At Norris, CK Post, and Van Dyke, men and women sat separately. Stutzman had assigned seating. At Kingsboro, patients ate in shifts. Of the 13 ATCS, Bronx and Creedmoor did not have dining rooms that were accessible to patients with physical disabilities. Since the Commission's site visits, Bronx has made its dining room accessible. Creedmoor's dining room is not accessible to patients with mobility impairments, but has longstanding agreements with South Beach and Manhattan to transfer patients with specific mobility needs. Creedmoor also has a capital project, presently in the planning and design phase, to address the dining room issue.

During observation of meals it was noted that patients had an adequate amount of food. Meals appeared well-balanced although somewhat carbohydrate-laden. In addition, food service and preparation areas were clean. Commission staff learned that Kingsboro was the only ATC that made meals on site. The remaining ATCs had meals brought in from their neighboring host facility. With the exception of Kingsboro, all ATCs had special diets available and offered alternate entrees. Snacks were available in-between scheduled meal times.

Environmental Summary

The Commission's environmental review found all 13 ATCs to be generally clean and in good repair. Best practices were noted in the areas of bedroom décor, specialized activity areas, dining amenities, and meals. Although accessibility was an issue at several ATCs, the Commission learned that OASAS will transfer the admission of patients with mobility impairments to an ATC that can accommodate them.

Programming

During the environmental review, Commission staff obtained a copy of each ATC program schedule and checked to see that programming was occurring as scheduled. At all the ATCs, programming was observed to be occurring as scheduled.

In reviewing the program schedules it was noted that days were long, beginning around 6:00 a.m. and ending around 11:00 p.m. Most ATCs had one schedule for all patients. However, others had specialty tracks or rotating schedules. For example, at McPike, patients were assigned to different specialty groups depending on their needs. At CK Post, newly admitted patients (first 3-4 days of treatment) had a different schedule than patients who had been at the ATC for a longer time. At Van Dyke, patients were divided into teams with each team having three schedules that rotated every week. At Creedmoor, men and women followed the same schedule but took part in gender-specific groups.

The amount of free time that patients had varied. At some ATCs such as McPike, patients attended groups back to back while at other ATCs patients might have an hour between groups. At Bronx, patients had "downtime" every other day from 3:45 p.m. to

5:30 p.m. Patients are expected to use this “downtime” for journaling and other self-reflective activities.

Finally, some ATCs offered specialized treatment. For example, Creedmoor, St. Lawrence, Richard Ward, and Norris offered auricular acupuncture. Manhattan had a special track for Spanish-speaking patients. Norris had a track for the deaf and hard of hearing, which is the only such inpatient program in New York State. Stutzman and Richard Ward offered programs for parents and their children.

Programming Summary

The Commission found that programming occurs as scheduled at all of the ATCs. While patients’ days were long at all the ATCs, there were differences in the intensity of programming. In addition, there were differences in the types of programs offered and in the separation of men’s and women’s programming.

Patient and Staff Interviews

Commission staff interviewed a random sample of 10% of patients (who had been at the ATC for at least one week) in each of the 13 ATCs. Participation was voluntary. Patients were asked about programming, safety, what was helpful in their treatment, and what they would change about their treatment. A total of 72 patients (48 males and 24 females) were interviewed. Only two patients declined to be interviewed.

In addition, Commission staff interviewed 50% of ATC clinical and direct care staff from each of the two shifts that Commission staff were on site. ATC staff were asked about safety, what they enjoyed about working at their particular ATC, and what they would change if they could.

A total of 147 ATC clinical and direct care staff members (67 males, 80 females) were interviewed. Most of the staff interviewed (69%) worked the day shift, 19% worked the evening shift, and 12% worked varied shifts (both day and evening).

Patients’ perspectives on safety and programming

All patients were asked if they felt safe. The overwhelming majority of patients (98%) felt safe. Only one patient responded that she did not feel safe because there were not enough staff to prevent someone from walking on her floor at night.

Commission staff asked patients if programming occurred as scheduled. Again, an overwhelming majority (94%) stated that it did.

What patients find helpful

When patients were asked what was helpful about their treatment at the ATC, their top three responses fell into the categories of staff, programming, and peer support.

For example, comments about ATC staff included, “Counselors are very accessible, have a lot of heart,” “Staff are very nice and make themselves available,” “Staff push you here, its wonderful,” and “I don’t want to get mushy or nothing but the people actually give a damn about me.”

Comments regarding programming included, “The meetings,” “The focus on relapse,” “Small groups, easier to talk,” and “Acupuncture.”

Comments regarding peer support included, “Camaraderie among patients a good feeling,” “Being with people with the same addictions,” and “Peers all alike, no surprises, no judgments.”

Examples of other categories of responses included activities (choir rehearsal, karaoke), operations (the ability to change counselor), physical plant (clean facility), and food (“food is good”). Only patients at Kingsboro and RC Ward made positive comments about the food.

What patients would change

When asked what they would change, the number one patient response was food. This was followed by comments concerning programming and facility rules.

Specific comments about the food included many general statements such as, “Food stinks.” However, some patients were more specific in their complaints about food and made suggestions such as, “Need more fresh fruits and vegetables,” “Food is all starch,” and “Need more variety.”

Programming came in second with patients offering suggestions such as “Too much group during the week,” “Would like to have co-ed groups so each sex can hear the others perspective,” “More small groups,” and “More structure, I have a 3 hour gap during the day.”

The third most frequent response was facility rules. Patients commented on issues such as wanting looser phone privileges and being able to smoke.

Other areas that patients would change were activities (more recreation, more time outside), physical plant issues (laundry soap itchy, more showers), and operations (poor orientation, meal lines take too much time).

Staff perspectives on safety

With the exception of South Beach (which was the Commission's pilot ATC), all staff were asked if they felt safe working at their assigned ATC. As with patient's, the overwhelming majority of staff interviewed (90%) responded that they did. All staff interviewed at CK Post, Creedmoor, Blaisdell, Richard Ward, and Van Dyke reported feeling safe. At the remaining ATCs, there was at least one staff member who reported that they did not feel safe at least part of the time.

Of the 14 staff who did not feel safe, the majority were women (11 women, 3 men). In addition, most of the staff members, 10 out of 14, were nurses. The remaining staff members were two addiction counselors and one intake worker. Finally, half of the staff members who reported not feeling safe worked the day shift. The other half worked either the evening shift or varied shifts.

Staff at McPike and Manhattan mentioned that they were treating more patients with concurrent mental health issues and were concerned about being threatened by these patients and that Safety Officers² are slow to respond. Staff at Norris, Stutzman, and Kingsboro mentioned that certain patient behaviors, such as verbal aggression and possession of contraband, made them feel unsafe. Staff at Bronx and St. Lawrence were concerned about not having enough staff. Finally, a staff member at Norris mentioned building security at night.

What staff enjoy

When staff were asked what they enjoyed about their jobs, the most common responses fell into the categories of the work itself, the patients, and co-workers.

When responding about the work itself, staff made comments such as "I love what I do," "The change...things are never the same from day to day," "I like the field, it's a challenging population," and "Love the responsibility."

In the patient category, staff made comments such as, "I like to see patients get their life back," "Have close interaction with the patients," "Seeing patients grow," and "Helping people."

When responding about co-workers, staff mentioned teamwork, camaraderie, expertise, and support.

Other staff comments included the programming that their ATC offered, management (being supported by management, having staff input valued), and personal issues such as having a steady job and being able to work close to home.

² OMH employees stationed at the ATCs' neighboring psychiatric center

What staff would change

When asked what they would change, the majority of staff responses fell into the categories of operations, staffing, and physical plant.

Comments regarding facility operations included having more time to spend with patients, better intra-agency communication, increasing patient length of stays, addressing staff disagreement on and unfamiliarity with facility rules, and lessening the number of patients leaving against clinical advice.

Comments regarding staffing included wanting more staff, wanting better staff, and changing the facility's hiring practices.

Staff comments about the ATC physical plant included wanting bigger and better space, improving the food, changing the physical layout of the building, and wanting new furniture and equipment. Other staff comments included wanting more specialty groups and activities, wanting more support and direction from administration, and wanting better pay and work schedules.

Patient and Staff Interviews Summary

From the patient's perspective, staff are OASAS' biggest asset. In addition, patients commented that programming is helpful but added that various changes in this area might be helpful as well. Finally, patients were specific about what their food dislikes were.

Most staff feel safe at their facility. However, those who didn't feel safe gave reasons that OASAS may want to address with staff training and/or further exploration of staff concerns. Finally, OASAS may want to capitalize on what staff enjoy about their work and consider staff suggestions for improvement.

Incident Reporting

OASAS policy on incident reporting and management defines an incident as "any event which has an adverse effect on the life, health, safety, or well being of any individual receiving services, or on any member of the staff if not elsewhere reported, or the death of any person on or off premises, if such person is currently receiving services from the ATC." The policy states that a written incident report shall be completed and that all incidents shall be investigated. The Commission's review of the individual ATC policies on incident reporting and management revealed that each ATC adhered to OASAS' guidelines. In fact, most ATCs mirrored OASAS policy word for word.

While on site, Commission staff reviewed one month of staff communication logs to see if there were events occurring at each ATC which would have an adverse effect on the life, health, safety, or well being of the individuals receiving services. Commission staff then asked for copies of incident reports (along with any investigations and supporting

documentation) for the same month to determine if such events were being reported as incidents. Finally, the incident reports themselves, along with any corresponding investigations and supporting documentation, were reviewed to determine how incidents were being managed.

Incidents reviewed

The Commission reviewed a total of 154 incident reports.

The most common types of incidents reported, accounting for over 83% of the total reviewed, were: 1) missing patients and patients discharged against clinical advice, 2) medical emergencies, psychiatric emergencies, and patients taken to the ER, 3) rule violations/administrative discharges, and 4) minor patient injuries.

The fifth most common type of incident reports that the Commission reviewed included events that the Commission would not necessarily define as “incidents.” These incident reports included events such as telephone service being repaired, hall monitors not working, and staff accidentally setting off the fire alarm. We found that Richard Ward had the most incident reports of this type.

The review of communication logs revealed 16 events that were not reported as incidents. With the exception of Van Dyke and Richard Ward, every ATC had at least one event that was not reported. Most of these unreported events, 10 out of 16, fell under the category of medical emergencies/ER visits. These included events such as “Patient sent to ER for complaint of chest pain,” “Patient taken to hospital, admitted.” The Commission also found three references to sexual contact between patients. For example, at one ATC, a female patient reported that a male patient had grabbed her buttocks. At another, staff observed two patients having inappropriate contact in the laundry room. Finally, there were three instances in which a missing patient was not reported as an incident.

In reviewing communication logs, the Commission noted one event that, while not necessarily meeting the criteria of an incident, did seem to warrant further inquiry. An entry in the February 2004 South Beach staff communication log documented that an ex-patient came to the unit, stated he was there to see a staff member, and thereafter left and broke a current patient’s confidentiality. This entry noted that, “there are several confidentiality issues we need to address.” The Commission was particularly concerned with this entry, as we were also able to easily access the unit during our unannounced site visit and walk around the unit without being questioned³. It is the Commission’s understanding that South Beach Psychiatric Center’s capital plan includes moving the ATC to its own floor. This will allow the ATC to control access to the entire space that it occupies.

Our review of communication logs also found references to events that were apparently investigated but not filed as incidents. Specifically, an entry from Stutzman makes

³ South Beach PC reportedly will not allow the ATC to install a buzzer

reference to an event in which one patient cut another patient's hair. An entry from Van Dyke makes reference to an incident of harassment for which a patient was subsequently discharged. Although both of the aforementioned entries indicate that an investigation had been conducted, neither agency had filed a corresponding incident report or documented their investigation. Thus, it is unclear what exactly happened and what the rationale was for the decision to administratively discharge the patient.

Variations

The Commission noted that most ATCs use the OASAS TRS-26 incident report form. However, there was a slight variation, with Blaisdell using OMH Class D Incident Log forms. This practice was discontinued in April 2005 and Blaisdell ATC now uses form TRS-26 for all incidents. While all of the ATCs adhered to OASAS policy, two ATCs went beyond. Specifically, Creedmoor's policy includes expectations for the management of incidents involving visitors. In addition, if an incident occurs during an activity at Creedmoor, staff are to indicate whether it was during a scheduled or unscheduled activity. Finally, RC Ward expanded their list of reportable incidents to include instances where program rules are violated. OASAS may want to look at the supplements Creedmoor and Richard Ward have added to their policies to determine whether they are worth replicating elsewhere.

The Commission found variability in ATCs reporting patients discharged against clinical advice (ACA) as incidents. OASAS policy states that, "All against clinical advice discharges that occur without staff knowledge shall be deemed an incident and require the completion of an incident report." While some ATCs (such as Stutzman and Kingsboro) followed OASAS policy and only filed incident reports on those patients who left treatment without first telling staff, others (such as Manhattan and Richard Ward) filed an incident report on all patients leaving ACA, regardless of whether they told staff they were leaving.

In reviewing incident reports of patients discharged against clinical advice the Commission found that the reasons patients left treatment did not always appear to be fully explored. While there were incident reports documenting a patient's refusal to discuss their reasons for leaving or documenting that a patient left treatment without telling staff, there were other reports that simply noted "patient left ACA." Thus, it was not always clear whether the patient left treatment without telling anyone, left treatment but refused to discuss the reasons, or gave reasons that were not documented on the report. Other incident reports on patients discharged against clinical advice included the patient's reason for leaving but seemed to warrant further inquiry. For example, one patient left treatment because she did not feel comfortable on the unit. Whether this patient refused to elaborate why she felt uncomfortable or simply was not asked is not documented. Finally, several ATCs (such as Manhattan) make reference to an exit interview. However, patient responses were not always documented on the incident report.

Subsequent to this review, the Commission learned that many ATCs collect a great deal of information about patients leaving treatment against clinical advice and record this information in the clinical record. It was expressed that including this information on the incident report would be unnecessary and duplicative. However, OASAS may want to consider centralizing such information to better assist them in preventing patients from leaving treatment prematurely. For example, including certain key information on an incident report would make it easier to obtain data and identify trends.

Summary

Our review of ATC incident reporting practices found that ATCs report most incidents as required, some ATCs are reporting events that are not classified as incidents, and ATCs vary on reporting patients leaving ACA as incidents. To assist in their efforts to lessen the number of patients leaving treatment prematurely, OASAS may want to explore including more information on ACA incident reports so that data and trends in this area can be more easily extracted.

Policies and Procedures

OASAS and individual ATC policies and procedures were reviewed off-site. Specifically, the Commission requested both OASAS and individual ATC policies and procedures on admission, patient rights, incident management, workplace violence prevention and intervention, medical and psychiatric emergencies, and discharge. Each policy was reviewed to determine how the individual ATC policies compared to the OASAS policy and how they compared to each other.

Admission

OASAS regulations prescribe standards for admission to chemical dependence inpatient rehabilitation services. Among other things, these standards require that the individual seeking services, or having been referred for such, appears to be in need of chemical dependency services; is free of serious communicable disease that could be transmitted through ordinary contact; and is not in need of acute hospital care, acute psychiatric care, or other intensive services which cannot be provided in conjunction with inpatient care and would prevent him or her from participating in chemical dependency services.

Additionally, the person must be unable to participate in, or comply with, treatment outside of a 24-hour structured treatment program.

OASAS regulations require that admission determinations be made based on service provider records, reports from other providers, and/or face to face contact with the individual and that the determinations on the appropriateness of the level of care be documented by qualified persons.

OASAS regulations also prohibit discrimination and provide that no individual shall be denied admission to an inpatient service based solely on, among other things, past history or contact with the criminal justice system, inability to pay for services, pregnancy, physical or mental disability, HIV/AIDS status, referral source, and maintenance on Methadone or other medications prescribed and monitored by a qualified medical professional.

To assure consistent compliance with OASAS' regulations, the Commission reviewed each ATC's policies on admissions. Generally, it was found that the admission policies detailed processes by which ATCs: gather and assess information on referrals, make determinations on the appropriateness on admissions consistent with OASAS admission criteria, and, when admission was not appropriate, refer the individual to more appropriate services.

The Commission's review of ATC admission policies revealed some differences which warrant further discussion as to what might constitute better or best practices. Specifically, differences were found in the areas of: substance use at the time of admission, possible barriers to admission to a particular ATC, source of referrals, and special populations and priorities for service. It should be noted that since the Commission's review, all ATCs have changed their admission policies to be in compliance with current regulations and local service bulletins in these regards.

Five of the ATCs required that persons seeking admission be alcohol and drug-free at the time of admission. Blaisdell required that the person be alcohol and drug free for 72 hours prior to admission; South Beach, Creedmoor, and Norris required that the person be alcohol and drug free for 48 hours prior to admission; and CK Post ATC required that the person be free of substances of abuse on the day of admission.

Conversely, six of the ATCs appeared to accept persons who were intoxicated or under the influence of alcohol or drugs at the time of admission. They were Manhattan, Van Dyke, Bronx, RC Ward, Kingsboro, and Stutzman ATCs. Specifically, the policies of most of these ATCs indicated that if the person was too intoxicated, so as to require medical detoxification which the ATC cannot provide, the person would be referred out for such. The policies of the two remaining ATCs, St. Lawrence and McPike, indicated that breathalyzers were administered at the time of admission. However, it was not clear whether this was done to ensure that the person was alcohol-free or not so intoxicated as to require medical detoxification.

In reviewing admission policies, it appeared that certain ATCs have barriers to admission that others do not⁴. These barriers fall into three categories: accessibility, medications, and diagnoses.

⁴ While no one is actually denied admission, they may be referred to another ATC outside of their catchment area

Five ATCs required that persons seeking admission be ambulatory or able to negotiate stairs without assistance. They were Creedmoor, Van Dyke, Kingsboro, Stutzman, and Manhattan.

Creedmoor is not accessible to individuals with mobility impairments but has agreements with South Beach and Manhattan to refer patients who are not ambulatory or cannot negotiate stairs without assistance. Van Dyke has the same agreements with Norris and McPike.

Kingsboro, Stutzman, and Manhattan are actually accessible. However, their policies still indicated that being ambulatory is a criterion for admission. In addition, Manhattan and Stutzman's policies stated that individuals needed to be ambulatory but also noted that their facilities are accessible to individuals with wheel chairs. For example, page 3 of Manhattan's policy states that "MATC is accessible to wheelchairs and other handicaps." However, page 6 notes that "Factors for admission to treatment...medical functioning...must meet the following two criteria...The consumer is ambulatory or has no medical complications that would hamper his or her participation in residential treatment." The policies of these three ATCs have since been changed.

RC Ward and Norris indicated that they accept individuals with mobility problems. The policies of the remaining six ATCs (St. Lawrence, Blaisdell, Bronx, South Beach, CK Post, and McPike) did not touch upon the issue of mobility.

The admission policies of RC Ward and McPike (for example) explicitly state that, upon careful review, they admit individuals on Methadone, controlled substances, or other medications prescribed by physicians. However, the policies of two other ATCs seemed to categorically deny admission to individuals on certain medications. For example, Norris' policy indicated that no individual will be admitted who is taking more than a maintenance dose of psychotropic medications (as defined in the Physician's Desk Reference), minor tranquilizers, or sleeping medications. Manhattan's policy indicated that individuals taking benzodiazepines, Zaleplon, Clozapine, Triazolam, or Zolpidem will not be admitted. Manhattan's policy also indicated that being on Methadone maintenance is one of the reasons a person may be deemed clinically inappropriate for admission. The remaining ATC policies do not specify whether they admit individuals on certain medications or not. However, the Commission has since learned that all ATCs have changed their admission policies to be in compliance with current regulations and service bulletins in this regard.

Certain diagnoses also appeared to present barriers to admission to certain ATCs. CK Post's policy seemed to deny admission to individuals who have a personality disorder as their only mental health diagnosis and to women who are beyond 30 weeks of pregnancy. OASAS has agreed to change this policy. Norris' policy listed as conditions precluding admission: organic mental disorder, severe personality disorder, and impulse control disorders of pyromania or intermittent explosive disorder. Norris' policy also seemed to indicate that people with I.Q.'s below 80 would not be admitted to the facility unless cleared by a psychiatrist or a psychologist. Norris' policy has since been changed to

indicate that only individuals under the age of 18 would be precluded from admission. Bronx's policy prohibited the admission of people with "advanced" organic brain disease. Finally, Manhattan's policy bars the admission of pregnant women in their third trimester. Manhattan ATC has since changed their policy to allow admission unless there are certain medical conditions that would prevent such.

ATC admission policies usually referenced the agencies from which they received referrals. Typically, referral sources were human and social service agencies, addiction treatment agencies, criminal justice agencies, mental health agencies, and a variety of other professional services or qualified practitioners. It was not always clear whether these lists were exhaustive, and in a number of cases, they probably were not. However, in one case, that of RC Ward, the policy explicitly stated that they accept referrals from self help groups and members of the community. Conversely, the policy of Van Dyke ATC stated that they do not accept self-referrals and referrals from self help groups, as such sources are not familiar with level of care criteria. Individuals seeking assistance in this manner are referred back to community agencies that are more familiar with the OASAS system and levels of care. The policies of the remaining ATCs were silent on the issue of self or self help group referrals.

The admission policies for certain ATCs indicated that they were designated to serve special populations statewide and for these purposes would accept admissions from other ATCs upon their deflection. They were: Norris ATC for people with hearing impairments and mobility difficulties, Manhattan ATC for Spanish-speaking persons, and Stutzman for Native Americans. Additionally, the policies of Stutzman and RC Ward ATCs indicated that they have programs serving a very unique need: parents with children, in which the children may stay with their parent during the course of treatment. However, it was not clear if these unique programs accepted admissions statewide⁵.

Policies for some ATCs identified priorities for admissions or for managing waiting lists within their catchment areas. Norris ATC, for example, gave priority to people who are under 19, are HIV+, or use IV drugs. Among McPike's priorities were pregnant women, people with children in, or at risk of foster care, Native Americans, and children of adult substance abusers. Finally, Bronx ATC gave priority to individuals who are victims of domestic violence and/or who are at high risk of relapse or for whom relapse would pose high medical and/or clinical risks.

The ATC's excellent efforts to serve special populations give rise to consideration as to whether all special populations in-need are being served; whether certain unique programs are available state wide; and whether there is, or even should be, consistency in priorities for ATC services across the state.

For example, should there be special programs for people with sensory deprivations other than deafness or special programs for individuals who are cognitively impaired? Can parents with children in other parts of the state receive services similar to those offered by Stutzman and RC Ward ATCs? Can individuals who speak Spanish (as well as other

⁵ Specialized ATC programs do accept admissions statewide

non-English languages) receive services across the state? Finally, Should IV drug users or people who test positive for HIV in the Bronx be given the same priority for service as those in the Rochester area?

Patient Rights

Interested in the efforts made by the ATCs to uphold patients' rights, the Commission reviewed ATCs policies on this matter along with any information provided to patients concerning their rights and responsibilities. Upon admission to an ATC, patients are given the Formal Notice of Status and Rights, which advises them of their admission status under Mental Hygiene Law and the availability of the Mental Hygiene Legal Services. Patients are also given a Notice of Confidentiality and Rights, which describes the confidential nature of their care and treatment, the federal statutes protecting such, and the means by which to register complaints.

One of the most valuable pieces of information provided to patients upon admission is a Patient Handbook. Developed by and tailored to each ATC, the handbook typically offers a welcoming statement along with an overview of the facility and treatment process. These handbooks also offer information on topics such as visiting, telephone use, mail, rights, grievance procedures, and patients' responsibilities. The Commission was impressed with the array of topics covered in the ATC handbooks. It also found the handbooks to be valued tools for orientating patients to the facilities they are entering, informing them of what they can expect during and from their stay, and informing them of their responsibilities as patients.

All the ATCs allow for visiting, telephone use, and mail. However, the rules surrounding such vary somewhat among individual ATCs. At most ATCs, visiting days are either Saturday or Sunday. In addition, almost all of the ATCs allow visiting from the onset of admission. However, two do not. Norris allows visiting beginning on the second weekend into treatment and CK Post allows visiting beginning on the third weekend.

Nine of the ATCs make visiting contingent on the visitor first attending a "family program." These programs are designed to orient the patient's family member or significant other to the nature of chemical dependency and the recovery process. Four ATCs do not require participation in a "family program" as a prerequisite for visiting. For example, Bronx and Manhattan have such programs but do not require attendance a prerequisite for visiting. However, Bronx ATC reported that they have a family orientation/education program that is built into each visit in the form of pre and post-visit meetings. Creedmoor and South Beach, the only ATCs offering visitation on *both* Saturday and Sunday, require that anyone choosing to visit on Sunday must first attend the "family program" offered that day. Saturday visitors do not have to attend the family program. Creedmoor and South Beach now require attendance on both days.

As with visiting, rules surrounding telephone use varied among ATCs. Approximately half of the ATCs had fairly liberal policies surrounding telephone use. Their patient handbooks described the availability of public phones for outgoing calls during non-

programming hours, but with the caveat to keep the calls under 5-10 minutes, so as to allow other patients the opportunity to make calls.

The policies of other facilities seemed to be more restrictive. At South Beach, for example, the patient handbook informs patients that they are allowed to make one phone call every three days. RC Ward allows one telephone call a week with a pass given by the case manager. Van Dyke requires that patients receive a note from their therapist in order to make a call. Blaisdell's patient handbook states that there are no social phone calls but allows business calls to be made with the patient's case manager. At CK Post, telephone calls are permitted only for specific and clearly documented therapeutic reasons. Finally, Bronx discourages telephone use and requires that patients see their counselor if they need to make a call during the first three weeks of treatment. After this time period, a public phone is provided if the patient has an honor card.

All ATCs allow for patients to send and receive mail on a regular basis.

With the exception of CK Post, which gives patients a separate, two-page statement of patient rights along with the patient handbook upon admission, all patient handbooks detail patient rights. These statements of rights essentially echo those published by the OASAS Client Advocacy Unit patient brochure.

At most ATCs, the rights discussed in the patient handbooks go beyond those articulated by OASAS' Client Advocacy Unit. For example, eight ATCs include the right to know the name, position, and function of any person providing treatment. Three ATCs include the right to request the opinion of an outside consultant (at ones own expense) or to request an internal review of the individual treatment plan. Two ATCs include the right not to be required to perform labor or personal services for any staff, to engage in activities not directly related to treatment, or be subjected to coercion or undue influence.

The Commission also found that each ATC describes in its patient handbook a step-by-step grievance process should patients have complaints about their care or treatment. Patients are advised to first speak with their counselor or primary therapist and follow the chain of command, eventually up to the Directors level if need be. Some ATCs suggest that the concern initially be put in writing and even have specific forms for such. Other ATCs suggest that concerns only need to be in writing when they are brought to the Directors level. However, all ATCs inform patients of the existence of the OASAS Client Advocacy Unit in Albany, its toll free number, and its ability to be of assistance if concerns cannot be resolved at a facility level.

In addition to informing patients of their rights and grievance procedures, the ATC patient handbooks also inform patients of their responsibilities. The handbooks generally do this in proactive, positive ways; speaking to the importance and therapeutic value of responsibilities such as keeping ones room neat, appropriate dress, and respecting others.

The ATCs also make clear behaviors that will not be tolerated and may lead to a person's discharge. Chief among these are the use of alcohol and drugs, violence, threats of

violence, harassment, stealing or property destruction, and sexual, physical, or intimate relationships with other patients. In addition, at the time of the Commission's review, two of the ATCs, Norris and Stutzman, included the use of tobacco products. The Commission believes that the latter two behaviors (intimate relationships and the use of tobacco products) may warrant further review by OASAS.

The Commission recognizes the negative effects sexual or intimate relationships may have on patients during the initial and intense phase of inpatient recovery. However, there was a wide range in how such relationships were discussed in patient handbooks. The Commission believes that the manner in which the issue of relationships is presented to patients warrants further review.

At one end of the spectrum there is the Norris ATC handbook that covers the topic tersely in three sentences, "Fraternization between male and female patients is not allowed. Fraternization is defined as verbal and non-verbal interaction with peers of the opposite sex. Sexual activity between opposite sex and same sex is not tolerated and will lead to discharge." Likewise, RC Ward's handbook lists engaging in any interaction with members of the opposite sex as grounds for administrative discharge.

At the other end of the spectrum, the patient handbooks of CK Post and Stutzman devote a more thorough explanation of the issue. These ATCs discuss the importance of certain types of relationships in recovery, the dangers of others, the temptation of "rehab romances," and the likely outcomes of such. They also explain how patients can build healthy relationships and avoid unhealthy ones.

Given the importance of this issue and the fact that most ATCs are co-ed facilities, OASAS may want to review the various approaches ATCs use to discourage intimate relationships in order to determine which approach is most effective.

Concerning the use of tobacco products, the Commission acknowledges the health-threatening nature of this addiction to both the smoker and those around him or her. However, while several ATCs integrate the treatment of nicotine dependence and ban smoking completely, others permit smoking on their grounds, in designated places, at designated times. Some of these smoking facilities still warn patients of the danger of smoking, discourage it, and offer interventions to assist patients to quit. Until all the ATCs integrate the treatment of nicotine dependence and ban smoking completely, it seems unfair that in certain regions of the state, a patient can be administratively discharged from an ATC for a behavior that is allowed in ATCs elsewhere in the state. As mentioned previously, all ATCs will be smoke free by March 31, 2006.

Workplace Violence

Preventing workplace violence is of great importance to OASAS. Their workplace violence prevention, intervention, and reporting policy offers guidelines on the assessment and control of risk factors, response and reporting of violent incidents, management of violent situations, and provision of staff training.

In response to the Commission's request for individual ATC policies on this subject, all facilities either said they followed OASAS policy or provided individual policies that essentially mirrored OASAS policy. While the Commission's review did not look at individual violence prevention programs, staff at various ATCs commented favorably on the training they receive in this area. Since the Commission's site visits, all ATC staff have taken a 2 ½ day training on violence intervention and prevention.

Medical and Psychiatric Emergencies

Each of the ATCs has policies concerning the management of medical and psychiatric emergencies. Upon review, it was found that each ATC policy universally addressed:

- The role of staff in responding to, assessing, and treating such emergencies.
- Steps for transferring patients to local emergency rooms or hospitals.
- Documentation expectations, including documents to accompany the patient.
- Family notification, providing permission was granted by the patient.
- Provisions for readmission to the ATC once the patient's condition is stable.

However, there were also some differences. Specifically, differences were found in the ATCs practices of staff accompanying patients in emergency situations and staff certifications in emergency procedures.

Whereas some ATCs policies are silent on the issue of whether ATC staff should accompany patients to local hospitals in emergency situations, others are not. RC Ward's policy states that, "during transfer to area hospitals in emergencies, clients will be accompanied by an RC Ward RN and the clinical record to insure critical information is relayed accurately to care givers..." CK Post directs that patients are to be accompanied to the hospital by an ATC staff member but only "when appropriate." Bronx ATC policy states that it is not necessary for ATC staff to accompany a patient when EMS is called. Although its policy is silent on the issue, Manhattan implies that patients are not accompanied by staff when sent to the hospital. According to Manhattan's policy, patients are transported by EMS and given a Metro Card for return transportation to the ATC in addition to change for a phone call.

In reviewing the ATCs medical and psychiatric emergency policies, it was noted that two facilities addressed staff credentials. While this is an issue that may be addressed more fully in other policies that the Commission did not request for review (e.g. staff training and qualifications), what was seen in the two ATC policies was interesting.

At St. Lawrence and McPike, it is expected that all nursing and recreation staff maintain current CPR and First Aid certification. However, St. Lawrence also requires that ACAs be certified. While McPike does not require that ACAs be certified, it does require that physicians be certified.

OASAS may wish to examine these areas further to determine best or better practices.

Discharge

The Commission found that specific ATC policies concerning the discharge process were generally consistent with the key standards expressed in the OASAS Policy.

OASAS policy classifies the clinical and administrative reasons under which a patient may be discharged from an ATC, requires that a discharge plan be developed to address unresolved patient needs, and mandates that ATCs develop policies that comply with New York State regulations. The regulations classify the reasons for discharge and prescribe standards for the discharge planning process.

These include expectations that:

1. Discharge planning begins at the time of a patient's admission to a facility.
2. Discharge planning is to be done in collaboration with the patient and any significant others the patient chooses
3. A discharge plan is to be completed and reviewed by an interdisciplinary team
4. The discharge plan should identify the chemical dependence services and any other treatment, rehabilitation, self-help, vocational, educational, and employment services the patient will need after discharge.
5. The discharge plan identify the type of residence the patient will need after discharge, the specific providers of aftercare services to whom the patient has been referred, and the initial appointments for aftercare services; a copy of which is to be given to the patient at the time of discharge.
6. A discharge summary, describing the course and results of treatment, will be written and entered into the patient's record within 20 days of discharge.

With the exception of Bronx ATC, the policies of all ATCs explicitly expressed the reasons or classifications for discharge (the policies of the Bronx ATC simply made reference to the regulations on this matter).

Uniform and consistent with regulations, all ATC policies required that discharge planning begin at the time of the patient's admission and stressed the importance of patient involvement in the discharge planning process. An excerpt from Bronx ATC's policy is illustrative: "Discharge planning must always be mindful of the strengths, needs, abilities, and most especially the preferences of the patient. A person is unlikely to follow a plan she or he disagrees with or has little input into."

Likewise consistent with regulations, all ATC discharge policies called for the input or approval of the interdisciplinary team in the discharge planning process, required that the patient's aftercare needs for housing and other services be identified and that the providers of these services be listed (along with scheduled appointment dates and times), and required that discharge summaries be prepared following discharge.

While the policies of all the ATCs required the involvement of the patient in the discharge planning process, the involvement of significant others was not uniformly addressed. At some ATCs, such as Van Dyke and Norris, the role of significant others was expressly addressed in their discharge policies. For example, Van Dyke's policy

states that the discharge plan “should be the result of a collaborative effort including the patient, treatment team, patient’s family, and community agencies.” Few ATC discharge policies were as explicit on this matter. However, it should be noted that the Commission reviewed only discharge policies. It may be possible that the issue of family and/or significant other involvement in overall care (including discharge planning) may be addressed in other policies of the ATCs that the Commission did not review. This is an area that OASAS may want to explore further.

Second, while the policies of all the ATCs required that discharge plans contain the names of specific aftercare providers and dates of initial appointments, they did not consistently state that the patient should be given a copy of this information at discharge. Some facility policies directly address this issue and require that patients be given a copy of their discharge plan. Others utilize discharge forms that the patient is required to sign, thus indicating receipt of the written discharge plan. The remaining ATC policies did not address the issue of patients being given a copy of their discharge plan. Again, this is an area that OASAS may want to explore further.

Whereas some facilities use progress notes to document discharge activities and plans, other facilities, such as Van Dyke, Blaisdell, CK Post, and Stutzman, have developed specific forms to ensure that all the needed elements of a sound discharge have been addressed and are written in a single document which, as indicated previously, can be signed by and given to the patient. The forms developed by these facilities are somewhat different from each other, but serve a useful purpose. OASAS may want to review the different forms to see if any particular one, or an amalgam of several or all, would serve as a model for all facilities.

Second, a number of ATC discharge policies require follow up on patients to determine whether they kept their scheduled aftercare appointments. For example, Norris ATC sends letters to aftercare providers at three week, three month, and six month intervals to inquire if the patient has followed through with treatment and how the patient is managing their treatment process. McPike ATC sends a survey to aftercare providers one month after discharge to see if the patient adhered to the continuing care plan. At Creedmoor, the primary therapist calls the aftercare provider to determine if the patient followed through with care and adds this information to the discharge summary.

Finally, some ATCs, such as Norris, Manhattan, and Kingsboro, have policies requiring follow up on unplanned discharges to reach out to patients and make recommendations for services.

Conclusion

The Commission's review noted similarities among the 13 ATCs. During our site visits we found that all of the ATCs were generally clean and in good repair. In addition, our site visits and patient interviews revealed that programming occurs regularly. Finally, we noted that individual ATC policies were generally consistent and followed OASAS policies.

However, we also noted many differences among the 13 ATCs. Specifically, we found differences in ATC physical plants, programming schedules, types of programming offered, incident reporting practices, and various policies such as admission, patient rights, medical/psychiatric emergencies, and discharge.

Among these differences we noted best practices, which OASAS may wish to replicate elsewhere. Specifically, we observed that several ATCs provided humanizing effects in bedroom and dining room areas. Some ATCs had specialized activity areas. Several ATCs offered specialized programs to meet the needs of special populations. Patient handbooks were comprehensive and appeared to be a valuable resource to individuals entering treatment.

Finally our review also revealed some areas of concern. Specifically, several ATCs were not fully accessible to persons with physical disabilities. In addition, the policies of several ATCs appeared to bar certain populations from admission. While the special programming offered by some ATCs was certainly noteworthy, we were concerned about its availability to individuals in other catchment areas. Finally, we found variation in ATC rules and explanations of rules that could affect a patient's treatment outcome