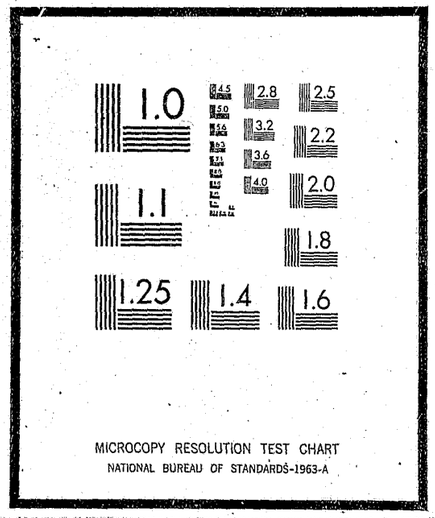

A REPORT BY THE BRONX COUNTY DISTRICT ATTORNEY CONCERNING THE CUSTODY AND CARE OF THE MENTALLY DISABLED CRIMINAL IN NEW YORK

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"MENTAL ILLNESS IS MENTAL ILLNESS WHETHER IT AFFLICTS THE CRIMINAL OR THE KING"

Judge Irving R. Kaufman in
United States ex rel. Schuster v. *Herold*
[410 F. 2d 1071, 1089 (2d Cir. 1969)]

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I ACKNOWLEDGMENT

Below are listed those persons who furnished the Bronx District Attorney's Office with pertinent information in response to requests made during this investigation into the mental health area.

In addition, assistants from the Bronx District Attorney's Office had the opportunity to speak with countless patients and therapists, as well as other professional and para-professional personnel throughout New York State in various public facilities. Because their identities were not ascertained or noted, we wish to thank them as a group for their valuable cooperation in this effort.

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Estella Williams	Cafeteria Worker, Bronx Psychiatric Center
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II PREFACE

On May 31, 1974, the Governor of the State of New York signed into law the "Matteawan" bill which in effect mandated the hospitalization, rather than incarceration, of all mentally disabled criminal defendants. By its enactment, the bill abrogated the statutory mechanism which had made possible the commitment of mentally disturbed defendants, adjudged to be potentially dangerous to themselves or others, to a prison instead of to a civil mental hospital. Implementation of the legislation appeared to dictate, in the face of an evident lack of available resources, that inevitably more and more potentially aggressive or violent patients would be housed in local mental institutions lacking adequate secure facilities. This, in turn, seemingly posed a potential threat to the safety and well-being of the communities and residents in the vicinity of these institutions.

In the months just preceding and subsequent to passage of the so-called Matteawan bill, events took place which, when disclosed to the public over a period of time via newspaper accounts, created in the Bronx and elsewhere an atmosphere of unrest. Ultimately, this caused the District Attorney of Bronx County to undertake his own investigation into the Bronx Psychiatric Center and into the related system of state and city agencies which provide psychiatric services to the mentally ill individual involved with the criminal justice system.

Those events, as recorded in the files of the District Attorney and as recalled in newspaper stories, are recounted here.

In the spring of 1974, suspicious fires at the Bronx Psychiatric Center resulted in the death of one of the hospital's patients. The suspected arsonist, another patient at the Center, was arrested and found incompetent to stand trial. He was sent right back by the court to the same hospital where he was once more placed in the ward in which the fire was alleged to have been set. Someone at the mental

hospital had obviously failed to take note of the patient's prior clinical and criminal history.

In early August, it became clear that mentally ill criminals were being routinely transferred (under the then little known bill passed by the State Legislature in May of 1974) from Matteawan State Hospital to local mental institutions which lacked adequate secure facilities. Other patients, including some who had been accused of serious crimes such as homicide or rape, were being released into communities under the state's mental health master plan which emphasized treatment on an out-patient, rather than in-patient basis. Because of insufficient funding or inappropirate allocations of available resources, the state had failed to provide adequate and suitable aftercare programs. Many patients discharged from state mental hospitals, for these reasons, were receiving little or no psychiatric care on a regular basis.

Some patients had escaped during the then past several months from state mental institutions in the metropolitan area: namely, Creedmoor, Manhattan and Bronx Psychiatric Centers. State Legislators began to speak out against the "dangerous situation" which had been created by the closing of Matteawan to all but convicted persons.

In addition, state and city legislative agencies were motivated to investigate the situation. Candidates for state political office, a congressman, and community representatives as well, expressed their concern regarding the risk that the presence of dangerously insane criminals in local institutions would have upon the civil patient population and on the communities in which the hospitals were located. In the Bronx, one woman stated publicly that she feared that her brother, who had been transferred to the Bronx Psychiatric Center from Matteawan, would escape and kill her son. The brother, who had eloped from the Bronx Center on three occasions before being sent to Matteawan, allegedly had threatened to "cut" the woman up. Officials at the Bronx

Psychiatric Center acknowledged, in response to these expressions of fear, that a dangerous situation had been created by the transfer of inmate-patients from Matteawan.

During the first days of August, it was also disclosed that fire safety at the Bronx Psychiatric Center had been seriously jeopardized as a result of the State's failure to have the institution's interior pull-box alarm system repaired for almost two years. Gubernatorial candidate, Hugh Carey, noting the report concerning the alarm system, called upon the Bronx District Attorney and others, on August 6, 1974, to investigate the alarm system, alleging "gross negligence and dereliction of duty on the part of hospital and state officials." Community representatives on the Board of Visitors of the Bronx Psychiatric Center publicly called for the protection of the hospital's patients from the unsafe fire conditions.

It later became evident that large numbers of mental patients, including dangerously incapacitated transferees from Matteawan, were escaping from the Bronx Psychiatric Center. The Bronx institution had failed on several occasions to properly report to the police the escape of criminally committed and dangerous patients, leading the police to believe the escapees were harmless civil patients.

Meanwhile, controversy continued between the City and State of New York over the number of psychiatric beds to be made available in the new Bellevue Hospital building, which had already been substantially completed. Between spring and mid-August of 1974, the adequacy of the State's aftercare program was continually called into serious question by various accounts of the tragic inadequacies of halfway houses or hostels (located throughout the State) for former mental patients.

By August 16, 1974, it was apparent, first, that the Bronx Psychiatric Center was experiencing inordinate difficulty coping with both non-dangerous and potentially dangerous patients committed pursuant

to the Criminal Procedure Law as being incompetent to stand trial or acquitted by reason of insanity; second, that the Center had been functioning administratively at a less than acceptable and perhaps negligent level; and third, that the conditions at the hospital called for some immediate corrective, if not prosecutorial action.

On that day, the District Attorney initiated an investigation into conditions at the hospital. This mandated a review of the nature and the adequacy of the related system of psychiatric care and treatment offered in this City to the mentally disabled defendant and convict. The report which follows is the result of that investigation.

III AN OVERVIEW OF THE SYSTEM OF PSYCHIATRIC CUSTODY, CARE AND TREATMENT OFFERED IN THE CITY OF NEW YORK TO THOSE MENTALLY ILL INDIVIDUALS INVOLVED WITH THE CRIMINAL JUSTICE PROCESS

The New York City "system" of psychiatric custody and care for mentally disabled persons involved with the criminal justice process consists of various city and state operated agencies and a number of private programs which have various responsibilities, sometimes overlapping, often confusing.

At the initial level of contact with the mentally ill criminal detainee are representatives of the police, the District Attorney and the Legal Aid Society. Following the arraignment stage, during which the detainee encounters (in some instances) private counsel, the judge, and court officers, the mentally ill subject is housed as either a detention case or city prisoner—unless released on bail or his own recognizance to receive out-patient treatment—in facilities run by the Department of Correction. This agency shares jurisdiction in certain psychiatric matters with the City's Department of Mental Health and Mental Retardation, the Health and Hospitals Corporation, the Department

of Health, and with its subagency, the Department of Prison Mental Health Services (which is an arm of Prison Health Services). Once an individual is found incompetent by the court, the State Department of Mental Hygiene provides psychiatric care and treatment in one of its mental hospitals until the patient recovers and is returned to the jurisdiction of the court or until dismissal of his criminal charges—at which point he or she is treated as one who has been recommended for civil commitment. At the aftercare level is the Department of Probation, the Department of Correctional Services and the vast network of facilities and services sponsored through voluntary, proprietary and municipal facilities. They offer psychiatric care on both an in-patient and out-patient basis. These agencies are, to varying extents, supervised by the State Department of Mental Hygiene, the State Department of Social Services, the City Department of Mental Health and Mental Retardation, the Department of Health and the Health and Hospitals Corporation.

All these various facilities and programs attempt to provide care and treatment at different stages in the criminal process and at points following the criminal detainee's release from a correctional or mental hygiene institution.

The Police Department, the Department of Correction, the Department of Mental Health and Mental Retardation, the Health and Hospitals Corporation, the Department of Health, the Department of Prison Mental Health, and the Department of Probation are part of the executive branch of the city government. Each department has a commissioner or head who is directly responsible to the Mayor.

The District Attorney is elected by the voters of his county.

The Department of Mental Hygiene is headed by a commissioner who is appointed by the Governor with the advice and consent of the Senate. The commissioner is responsible for the supervision and control of all the facilities, employees and of the structure of the depart-

ment. He is assisted by a Mental Hygiene Council and by advisory committees, the members of which are appointed by the Governor.

Each hospital under the department's control is run by a director appointed by the commissioner. The director is responsible for the supervision of the hospital's staff and the quality of the care and treatment made available to the in-patient and out-patient census of the institution.

The New York City area has a number of mental health committees composed of directors of community health services, directors of institutions in the Department of Mental Hygiene and directors of community mental health centers in or serving the area.

A number of other city, state and local agencies such as the Department of Social Services, the Civil Service Commissions of the City and of the State and the Bureau of the Budget also exert their influence on the nature and quality of care offered to the mentally ill person involved with the criminal justice process.

IV THE INVESTIGATION

A. The Purpose

The original purpose of this office's investigation was to determine whether any laws had been violated in the administration of Bronx Psychiatric Center with regard to security measures, fire safety practices, and with regard to the care and treatment of mentally ill defendants in its custody. It became apparent, however, that the entire mental hygiene system in the state and city would have to be studied to understand the problems at the Bronx Psychiatric Center.

The Bronx Psychiatric Center is just one state hospital in the largest state agency of any kind in the nation, in terms of budget and in-patient population: just one facet of a complex system of state and

local agencies and facilities which deal with the criminally committed mental patient. As such it would be virtually impossible for one to make intelligent, well-reasoned and practical recommendations concerning the hospital without first understanding the system as a whole and then understanding the role that the Bronx Psychiatric Center plays in that system.

Additionally, basic questions arose during the initial inquiry into the treatment and care of the mentally ill defendant at the Bronx Psychiatric Center, which led to the belief that an examination of the entire system of state and local care would be fruitful in providing answers and information. For example, should the criminal defendant be treated in a low security civil hospital in the first place or should he receive treatment elsewhere under intensive security? If treated in a low security hospital should the defendant be mixed with civil patients? What facilities are available around the state for the treatment of dangerous mental patients?

It became clear that the fundamental reason for the Bronx Psychiatric Center's difficulties in dealing with the criminally committed was the fact that the remainder of the "system" of state and local agencies had to some measure failed in effectuating appropriate screening and treatment of those mentally disturbed individuals charged with crimes. It appeared that a number of sociopaths were improperly being sent to the civil hospital where they would cause disruptions on the wards and from which they would escape. In addition, many patients seemed to arrive at the civil institution without having received appropriate treatment (other than medication) at some earlier point in the system. Assuming the individual was treatable, the hospital was then forced to expend that much more time and energy to cover therapeutic ground which may have been covered earlier. This, in combination with the fact that for a number of reasons state institutions have traditionally been the repository for the most severely disturbed mentally ill of our society, has, in part caused a situation in

which the hospital, due to limited resources, cannot devote as much manpower as it would like to the maintenance of the custody function.

An entire chapter has therefore been devoted to a description and analysis of the system of treatment and custody in the state and city which affects the Bronx Hospital.

B. The Method

The Bronx District Attorney in conducting this investigation, evaluated the State Department of Mental Hygiene, Department of Correctional Services, Department of Probation, and the New York City Department of Mental Health and Mental Retardation, Department of Prison Mental Health Services, Department of Correction, Fire Department and the Police Department, as they deal with the mentally ill defendant.

The actual investigation involved a number of different techniques.

Visits were made to Bronx Psychiatric Center, as well as to Manhattan Psychiatric Center, Creedmoor Psychiatric Center, Central Islip Psychiatric Center, Bronx Municipal Hospital, Bronx House of Detention, Mid-Hudson Psychiatric Center and Matteawan State Hospital. During excursions to these institutions, directors were interviewed about their procedures, programs, treatment methods, security practices and training programs. The facilities themselves were then thoroughly toured and observed. Staff members and patients were questioned. Security devices used for keeping patients in and intruders out were examined first-hand.

Many individuals from the various agencies and institutions were questioned extensively at the Office of the District Attorney of Bronx County. All individuals questioned, both in the institutions and in the Bronx Office, were requested to supply any and all documents relevant

to the investigation. They were also asked to supply leads to other sources of information. A large number of documents was gathered and then studied.

Police officials and fire marshals were questioned about security safeguards and fire safety at mental institutions. Specific cases of crimes and deaths due to fire were studied to better understand the problems.

The legal literature pertaining to the treatment of the mentally ill, including cases, statutes, law review articles and books, was thoroughly studied. The information thus gained was used as a basis for making recommendations.

V SUMMARY OF CONCLUSIONS

Fragmented—perhaps better than any word—describes the state of the "system" for the custody and care of the mentally disabled defendant and convict particularly in the Bronx and generally in the City of New York. State, City, and private agencies and programs in the City often fail, whether intentionally or not, to share information with each other about services for the criminal patient. Psychiatric referral services for the person involved with the criminal justice process is also lacking. Development of new forensic psychiatric programs and services is uncoordinated. Many ideas concerning forensic psychiatric matters lie dormant in the minds of those involved in the area simply because there is no central agency or body through which proposals of such a nature may be channeled to the proper authorities, coordinated and promoted.

Unlike civil patients who essentially are cared for in one institution and whose rights are assiduously protected by the Mental Health Information Service, the mentally ill defendant and convict is cared

for in a number of institutions run by various agencies which often do not adequately guard these individuals' rights.

One centralized authority is needed to coordinate all services, programs, facilities and personnel engaged in forensic psychiatric services and to provide referral services for all those mentally ill persons involved with the criminal justice process. This coordinator and overseer would develop programs and disseminate information concerning services available to the mentally disabled defendant and convict. He would have supreme authority in this area of mental health services in the city, funded by both the city and state. The coordinator should be appointed by the Governor with the advice and consent of the Senate for a term that overlaps that of the Governor. The office will therefore tend to be non-political. It would be responsible to the Governor and no one else. All existing services available would remain intact after the establishment of the coordinator. But final word concerning psychiatric services for the mentally disabled defendant and convict would remain, as we see it, with the office of the coordinator and not with existing agencies or programs.

Lack of planning in regard to facilities for the mentally disabled defendant, moreover, has resulted in a potentially troublesome situation in this city. Many mentally ill incompetent defendants are housed in state hospitals which are unequipped, and indeed were not originally designed, to provide the type of security which would assure the sustained confinement of patients, whether criminally committed or not. Aftercare for those who are released from state and city institutions is also deficient, in some instances non-existent, leaving a number of essentially untreated patients on the streets of communities in the metropolitan area.

It is thus recommended, first, that mentally ill individuals, involved with the criminal justice process (acquitted by reason of insanity, found incompetent to stand trial, awaiting trial, or convicted) be confined in forensic hospitals which have maximum peripheral security (in a rural setting) and maximum feasible internal freedom adjusted for individual patients. Aftercare programs should be improved to provide adequate and appropriate follow-up services for all mentally ill persons released from city and state institutions.

With respect to the Bronx Psychiatric Center it is recommended that security be tightened in the administration of the hospital. Facilities and personnel for the screening of those who enter and leave the institution should be expanded. Facilities, personnel and procedures there would be re-evaluated to determine what combination of factors has led to continuing elopements from the hospital.

Other security measures are recommended in this report for immediate implementation at Mid-Hudson Psychiatric Center located at New Hampton, New York. Its fences, for example, should be moved back, expanding its peripheral security facilities and opening up its interior grounds to the patient population.

The present structures utilized by the Department of Mental Hygiene at Mid-Hudson should be replaced in the near future by newer and more modern facilities.

Prison Mental Health Services in the city need be radically expanded and improved to make treatment programs available to all the inmates of local correctional and detention institutions.

L.E.A.A. funds should be obtained for many of the solutions propounded: with the aim of making one forensic hospital on the grounds of the Bronx Psychiatric Center. It could serve as the pilot project for all the state forensic hospitals to come.

The specific recommendations arising out of this investigation, in each of the many areas mentioned above are explained in the sections of the report discussing those particular aspects of the system to which the recommendations are addressed.

PART ONE

VI THE BRONX PSYCHIATRIC CENTER

A. Introduction

This part of the report is an analysis of the Bronx Psychiatric Center, covering its clinical as well as administrative practices, procedures and personnel. A similar analysis of the Mid-Hudson Psychiatric Center (the Department's secure facility for management problems and aggressive patients) is contained in Part Two of the report. Some of the problems and recommendations made later in respect to the procedures employed at Mid-Hudson when returning patients to the city prison system, apply to the Bronx Center as well. Reference should therefore be made to that subsequent section for a complete picture of the operation of the Bronx Center.

These two institutions, Bronx and Mid-Hudson Psychiatric Centers, of a total of some thirty-four state mental hospitals, have been chosen for detailed discussion for the following reasons. First, the Bronx Hospital was the original focus of the Bronx District Attorney's inquiry. Second, the Bronx Center is conveniently located at the Bronx D.A.'s back door, so to speak. And third, the Mid-Hudson facility is the only institution of its kind in the state (other than the recently opened building 21 which has just now become functional) and for this reason must be examined.

The two hospitals taken together present a representative sample of all the mental hygiene and mental institutions in the state.

The fundamental reason for Bronx Psychiatric Center's difficulties in dealing with the criminally committed was that the "system" of state and local agencies had failed to effectively screen mentally disturbed individuals charged with crimes. A number of sociopaths were being sent to civil hospitals where they acted out, causing disruptions

on the wards. Some of them escaped. Many patients were being admitted to civil institutions without having received appropriate treatment (other than medication) at some earlier point in the system. The hospital was for this reason compelled to expend that much more time and energy to furnish the therapy which may have been more effective earlier. It is also the fact that for a number of reasons state institutions have traditionally been the repository for the most severely disturbed mentally ill of our society. This has, in part, exacerbated the condition so that the Bronx Psychiatric Center cannot devote as much manpower as it would like to the custody function.

Accordingly, an entire chapter has been devoted to an analysis of the system of psychiatric treatment and custody in the State and City for the mentally disabled defendant and convict.

1. Capacity and Location

Bronx Psychiatric Center, with a 1,000 bed capacity, is one of 34 state hospitals operated under the jurisdiction of the Department of Mental Hygiene for the care and treatment of the mentally disabled and for research and teaching in the science and skills required for the care and treatment of such mentally disabled.

The Center occupies a 113 acre tract of land along the Hutchinson River Parkway in the South Bronx.

2. Admissions

The state institution accepts mentally disabled persons who cannot afford high-priced mental care or those who private institutions will not accept. One of the many reasons why private institutions may be reluctant to accept some of these patients is that they are severely ill and may be too disruptive in a low security private facility.

Basically, mental patients come to the center in several ways:

1. Informal civil commitment [pursuant to Mental Hygiene Law Article 31].
2. Voluntary civil commitment [pursuant to Mental Hygiene Law Article 31].
3. Involuntary civil commitment [pursuant to Mental Hygiene Law Article 31].
4. Adjudicated incompetent to stand trial [pursuant to Criminal Procedure Law Article 730].
5. Acquitted by reason of insanity [pursuant to Criminal Procedure Law Article 330].

There were 1900 admissions during the last year and the hospital's present in-patient census is approximately 600. There are 5,600 out-patients involved with the center, accounting for almost 26,000 visits to the institution per year.

3. Hospital Organization

The hospital and all its programs and personnel are under the control of the director who is appointed by the commissioner of the Department of Mental Hygiene.

Under the supervision of the director are a number of deputy directors, assistant directors and department heads. There are a number of service units (nine geographic units and the nine special service units), each with a head clinician. (Unless a patient has a special problem he will be placed in the unit which accepts patients from the area encompassing his last known residence). The units are usually divided into wards or service teams composed of both professional and para-professional staff members. Within each service team are usually a number of treatment units which actually deliver the psychiatric services to the patient.

It may be informative to present thumbnail sketches of the workings of two hospital wards, chosen at random from the many wards in operation at the hospital center.

THE RIVERDALE NORTH CENTRAL UNIT

(WARD 14)

Staff

The staff of the Riverdale in-patient service consists of 1 psychiatrist, 1 supervising psychiatrist, 1 psychologist, 1 social worker, 1 non-licensed medical doctor filling in on the social worker's pay line, 1 supervising nurse (R.N.), 1 registered nurse, and 17 therapist aides. The out-patient department consists of 1 psychologist, 1 supervising social worker, 1 social worker, 2 registered nurses, 3 therapist aides and 3 clinicians.

The supervising nurse of the in-patient service runs the ward administratively. Time sheets for non-professional employees are completed by the unit chief's secretary, the supervisor, or the therapist aide who has been put in charge of the shift. Professsionals work day hours in most instances and make up their own schedules. (They do not have to sign in.)

Shifts

There are six nursing staff persons (either nurses or therapist aides) assigned to each of the three shifts (i.e. day, evening and night). There are three persons required to be on duty at any one time during the shift; at night and during the evening all on duty are nursing personnel.

Supervisor

The supervising nurse, on duty during the day, and sometimes during other shifts, has the following responsibilities:

(1) Prepares the time sheets (keeping track of sick leave, etc.) for nursing personnel by coordinating schedules developed by the ward charges of the other two shifts. The supervisor must make sure no one works more than 5 days or entire weekends.

(2) Prepares daily supervisor's report on the gains and losses in patient census.

(3) Handles problems as they arise during her shift.

Meetings

Every morning the unit chief meets with the entire day staff of the in-patient service and all of its patients. This group sensitivity meeting lasts about one-half hour.

One day a week there is an in-patient ward, day staff meeting lasting one and one-half hours.

One day a week there is a unit wide meeting. Psychiatrists have rounds with in-patient ward treatment teams one hour a week.

The unit chief meets with evening and night shift one time per week.

The nursing staff sometimes holds its own meetings to discuss various problems.

Unit Chief

The unit chief has the following duties he must carry out in addition to his clinical functions:

(1) Prepares a monthly report which is essentially a narrative of the events which transpired on his service in the past month.

(2) Oversees the out-patient department's statistical reports.

(3) Distributes memos from administrative chiefs.

(4) Prepares a yearly budget request which is, in essence, a narrative summary.

(5) Oversees treatment plans—each unit has its own set format for components of a treatment plan.

At one time the unit's policies were formulated by the unit chief. Recently, many policies have been prescribed from above.

The Tremont Unit Ward 16

The unit is broken down into 4 teams: (1) the day hospital; (2) the in-patient ward; (3) the clinic; (4) crisis intervention team. We will explore the in-patient service headed by a psychiatrist.

Ward Charge

The head psychiatrist although theoretically in charge of Ward 16, has very little, if any control over the administration of his ward.

Virtually all of the administrative tasks are handled by the ward charge or someone appointed by her. On Ward 16 the ward charge happens to be a nurse. (It could be an attendant).

The ward charge assigns all the staff to its duties. The head psychiatrist, titled the team leader, may intervene in the assignment of personnel where an assignment will interfere with clinical matters. For example, the leader may want a particular staff member to spend time with a certain patient and therefore will ask that schedules be revised. Or, in the event he wishes to call a staff meeting, personnel schedules may be revised to assure that everyone attends. The assignment sheet is posted at the nurses' station. Without this sheet the ward leader (another name for team leader) would not know who was assigned at any one time.

Beyond being subject to the immediate administrative control of the ward charge, staff members are under the jurisdiction of

the department of which that employee is a part; for instance, the nursing department controls nursing functions, social service department controls social workers and so on.

New Ward Employees

Persons hired by the hospital are first screened by the department. If found acceptable, the applicant is then made available to the hospital service with the vacancy.

On Ward 16 a candidate for employment is interviewed, either before or after in-hospital training, by any member of the ward staff, by the ward charge and in *some* cases by the head psychiatrist himself. Apparently the ward leader relies upon the judgment of other staff members in a number of instances. A team meeting is then called and the ward staff decides whether the person who has probably been working on the ward for a while, is to remain or not. The personnel committee of the Tremont Unit would then have the final say as to whether the individual is acceptable for employment.

Shifts

On the day shift (8:00 a.m. to 4:00 p.m.) there are six or seven persons assigned. Three are usually on duty at one time; one of the three is a nurse, the other a social worker. Sometimes as many as five persons are working.

There are six persons scheduled to cover the evening shift (4:00 p.m. - 12 Midnight). No nurses or social workers are assigned.

The night shift (12 Midnight to 8:00 a.m.) is comprised of 6 nursing staff employees.

Meetings

The ward leader meets with the ward charge every Wednesday and the social service worker sits in every other week. The ward

charge may report back to the leader concerning the number of staff assigned. The initial allocation of staff is left to the team leader who works with department heads and the unit chief to secure an adequate number of staff members. The two discuss the relationship of the staff members with one another and with patients. They do not discuss the progress of patients or the competence of personnel (although they could discuss competence if the need arose).

The head psychiatrist or team leader, as he is called, meets with the day shift three times a week. On Monday, the staff has a training session. On Tuesday, there is a meeting of staff and patients together. Later in the day the staff meets to discuss patient problems. On Wednesday, rounds are conducted and each patient is discussed.

The team leader meets with the evening shift once a week and with the night shift once a month.

He also meets with the unit chief on occasion but they do not discuss personnel unless there is a need for additional ward employees.

There is no periodic evaluation of the competence of staff members.

All directives from hospital officials filter through the unit chief. If the head ward psychiatrist objected to a policy be would usually express his sentiments through the unit head.

4. Support Services

A number of supportive services such as maintenance and security have varied hospital functions. For example, the safety officers act as special hospital policemen and possess all the powers of peace officers. They wear uniforms but do not carry weapons except handcuffs to be used on extremely agitated patients who must be transported.

They have the power to serve simplified traffic informations and it is their duty to protect the grounds, the buildings and the patients.

The heads of support services work with the business office and with the hospital's administrators. The support service heads are thus responsible to some degree not only to clinical department heads but to the same persons to which the latter department heads report.

5. Control by the State Department of Mental Hygiene

In some areas of hospital administration (for instance, safety services) the State Department of Mental Hygiene has a bureau in Albany which exercises some direct control over hospital employees, through training programs or otherwise.

The department provides advisory personnel who perform services for all hospitals in a region. Each hospital can either reject or accept whatever information or advice is provided. This is particularly true in para-professional training programs. Although there are minimal training requirements established by the department, the details of training have for the most part been worked out by the Bronx hospital's personnel. According to Department of Mental Hygiene personnel, Bronx Psychiatric Center has one of the best training programs in the City.

6. Treatment

In-patient treatment consists of individual and group therapy, family therapy (family unit is treated as the sick organism), chemotherapy, occupational, art, music, and dance therapy, and cooking, dressmaking, cultural, and recreational activity therapy.

Outside the wards there are related projects available to patients on both in-patient and in many instances out-patient status.

There is a vocational rehabilitation program in which patients are paid at regular hourly rates, work for outside companies in jobs

at the hospital's multi-million dollar rehabilitation complex, which includes a patients' store, a gymnasium and a theater.

A nursery school program (PACE) is available to prepare patients with small childern for the problems they will face on returning home. The children are brought to the unit set apart from the regular in-patient buildings where their mothers care for them several hours during the day under the guidance of a staff member.

A day hospital is run on the hospital grounds as a learning center for adolescents and others who use the facility.

Apartment living is encouraged. This program entails the placement of elderly patients in conventional housing in the Bronx. Patients take care of the apartments themselves, do their own shopping and cooking and in general provide for their own needs without contact with the hospital other than brief visits during the week by a staff member.

Riverdale Manor is ostensibly operated as a private residential hotel with some staff supervision.

The hospital runs a drug-abuse in-patient and out-patient detoxification program on the hospital's grounds and an alcohol abuse program.

The Tremont Crisis Center, the Aftercare Clinic, the Co-Op City Satellite Clinic, and the Jacobi Out-Patient Clinic are also operated by the hospital. The clinics, staffed by psychiatrists, social workers and representatives of the neighborhoods, serve:

(1) As an emergency facility which can often prevent hospitalization by intervening at the time of the crisis and treating the person on an out-patient basis. It does so by a program of medication and individual and group therapy at the clinic. With practical action to ameliorate family, housing, job, economic and other problems troubling the patient.

(2) As an aftercare clinic that continues, in modified form, treatment begun in the hospital, thus serving as a sort of halfway house facilitating the patient's return to community life.

(3) As a place where someone who is troubled can come to discuss problems, make friends and thereby forestall more serious mental problems later on.

An extensive professional psychiatric training program through affiliation with the Albert Einstein College of Medicine and with the participation of its facilities, is conducted at the Center. The program covers residents in psychiatry, medical students, psychologists, interns, social-work students and nurses.

7. The Board of Visitors

Overseeing the operation of the hospital is a Board of Visitors, a group of seven non-paid community representatives appointed by the Governor, who are supposed to consult with and advise the director in all matters pertaining to the institution. By statute, the Governor is instructed to insure that membership of the Board adequately reflects the composition of the communities served by the facility and that membership of the Board shall include representation of the patients served by such facility through nomination of relatives of patients or former patients, or otherwise. The Board has the power to investigate all charges against the director and all cases of alleged patient abuse. They have the power to investigate and report to the director and the commissioner concerning the management and affairs of the Department facility.

a. Recommendations Relative to the Board of Visitors

The Board of Visitors of the Bronx Psychiatric Center should be commended for their good intentions and hard work. However, they have had little or no effect on the institution. The reason for this is that Boards of Visitors, in general, throughout the state have been given no power to effect change. They do have the authority to investigate problems in the institutions, but the power of investigation without the power to act on their findings is no power at all.

The well-meaning recommendations of the Board of Visitors have fallen on deaf ears in the past, and that should be corrected. In addition to the power of investigation, the Board of Visitors of the State of New York should have the power to demand corrective action by the agencies involved.

Over the past few years the Board of Visitors at the Center was well aware of the lack of security at the institution and the inadequate staffing to provide appropriate treatment in a safe setting.

At the November 26, 1973 meeting of the Board of Visitors they pointed out that there were not enough attendants to provide adequate treatment for the patients and to properly supervise and protect those patients.

On January 25, 1973, the meeting of the Board of Visitors requested more security personnel for Bronx State Hospital (the former name of the hospital). At the meetings of February 22, 1973, the Board reiterated its position that more security staff was greatly needed.

On May 24, 1973, the Board again pointed out that there was a great need for security personnel at Bronx State. Then, on May 30, 1973, the Board reiterated its position that more security staff was greatly needed.

The Board again made its position clear that more security personnel and more attendants were needed, at their November 26, 1973 meeting and their January 16, 1974 meeting.

On February 21, 1974, the Department of Mental Hygiene responded through a letter from an Associate Commissioner. The letter stated that their recommendations were being considered but, "we

cannot always assure you that the recommendations of the board of visitors will be implemented."

At their February 21, 1974, meeting the Board again pointed out the need for more new security staff and also discussed the fact there had been two vacancies in the staff for a long time. It was explained that the vacancies were not being filled because they had to be filled by people on the civil service preferred list.

On June 25, 1974, the Board of Visitors discussed the problems that the "Matteawan" legislation had created at Bronx State. They asserted that the patients transferred from Matteawan were disrupting other patients and also the staff. They recommended corrective legislation. They also again recommended more security personnel. After some time, 13 more security guards were finally acquired but only after numerous incidents at the hospital made the increase a necessity to quiet public reaction.

It is unfortunate that the Board of Visitors does not have more power to implement its recommendations. But equally disconcerting is the fact that none of the members are required to or in fact do have the requisite expertise to deal with the multitude of complex problems which arise at the institution every day. Community participation in the management of mental institutions is vital for balanced results but the only type of participation acceptable is that which is intelligent and well-informed, by individuals having some degree of sophistication in the mental health area.

It is therefore recommended that the Board of Visitors be given more direct say in the workings of the institution and that the Board itself be composed of at least one private psychiatrist, psychologist, social worker and lawyer, in addition to lay persons and parents of patients from the community. Members of the State Legislature in whose district the hospital lies and local elected officials should be *ex officio* members of the Board.

B. Security at the Bronx Psychiatric Center

1. General Introduction

First, it is useful to review an expanding area of statutes and case law which establish limitations on the degree of security, *i.e.*, restraints upon freedom within the institution which constitutionally may be imposed upon all the patients in a civil mental hospital.

a. The Law Pertaining to Hospitalization of the Mentally Disabled Defendant in Civil Mental Hospitals

While the need for protection of the public against potentially dangerous patients is a genuine concern, it should not obfuscate an equally important consideration: the effect, if any, added security measures in a mental institution, such as gates, fences, and guards, will have upon the rights and mental health of each patient in the hospital be he potentially dangerous, criminally committed, or not.

As in many areas of significant public policy, a balancing of the interests of the public and those of the individual within a contextual continuum of desirability and feasibility is required in determining the nature and extent of security appropriate at mental institutions. Further complicating this balancing process, however, is a number of judicial decisions and statutory amendments to New York law which have had the cumulative effect of changing the way persons traditionally characterized as "criminally insane" or "dangerously insane" may be treated.

In sum, where in the past those persons whose entrance into the mental health system was via the criminal law (*to wit,* convicted defendants, indicted defendants incompetent to stand trial and defendants acquitted by reason of insanity) were subject to confinement in maximum-security penal institutions, now only *convicted* defendants may be committed to mental health institutions under the jurisdiction

of the Department of Correction. All other mentally ill individuals even those characterized as dangerous, are committed only at institutions for involuntarily committed patients (Department of Mental Hygiene Facilities).

The changes in the law have apparently made more security measures necessary in the local mental hospital and have thereby thrown out of balance the equilibrium which had hitherto been attained between hospital security and the supposedly more open therapeutic hospital environment advocated by many in the psychiatric profession.

Commitment and Confinement of the Mentally Ill

Commitment of a person as mentally ill entails a substantial infringement freedom—a greater infringement than a convict would typically be required to endure in a prison setting. A brief review of the rationales relied upon as justification for such commitments is appropriate. There are essentially three:

1. Under a power traditionally termed *parens patriae,* the state may confine those persons who are mentally ill, but incapable of an intelligent decision to seek treatment.
2. In order to protect societal welfare—broadly defined—the state may commit those mentally ill persons who may constitute a danger to the public. This is an exercise of the police power. In contrast to *parens patriae,* the justification here is *not* the well-being of the ill individual, but rather the well-being of the public.
3. Persons convicted of a crime, whose mental illness evidently was not such to have precluded criminal responsibility, may serve all or part of their sentence in a penal institution for the mentally ill.

Except for individuals convicted of a crime, who may be confined in penal mental health institutions under the state's authority to punish convicted criminals, the characterization of a person as mentally ill and the diagnosis of the nature of his illness will ostensibly determine which of these rationales is used to justify his commitment. The rationale used will determine the type of institution to which he will be committed; and, in turn, the type of institution will determine the nature of institutional security.

The threshold issue of labeling people as "mentally ill" and specifying the nature of the illness is undoubtedly the most complex in the area of mental health commitments. Apart from the fact that mental illness is a controversial subject within the medical profession, it is an area that is not readily adaptable to legal or judicial analysis.

Dangerousness

As indicated, the public concern about persons who are mentally ill centers around the "dangerousness" of these individuals. Indeed, the characterization of the mentally ill as "dangerous" either to themselves or others furnishes the large part of the justification for their involuntary commitment. This concept of "dangerously mentally ill" is certainly relevant in determining the type of custodial care which is necessary in order to adequately protect both society and the patients. However, making an accurate determination of dangerousness—in keeping with the conceptual abstractness of mental illness itself—has proven to be a very difficult task.

As a result of a 1966 Supreme Court's decision in *Baxstrom* v. *Herold,* 992 patients who had been designated as "dangerously mentally ill" were transferred from a maximum-security Department of Correction mental health facility (Matteawan and Dannemora) to civil hospitals. Only seven of these people turned out to be too dangerous to remain for treatment in civil institutions in the community. The *Baxstrom* experience served to highlight an apparent tendency to overclassify mentally ill individuals as dangerous.

Evidently, even where sophisticated statistical methods were used for predicting "dangerousness," this tendency persisted.

In addition to the maze of considerations involved in a determination of "dangerousness," there are procedural and practical constraints on the capacity and propensity of the judiciary which may have contributed to an overuse of the "dangerous" label. Judges may be very reluctant to release to the community, or to commit to a less than maximum-security institution, an ostensibly dangerously ill individual. This is due in part to an awareness that such an individual may, should he be freed or escape, commit a violent act. Contributing to this judicial awareness is the fact that substantial media attention has been directed at incidents of "crimes" allegedly committed by mental patient parolees or escapees.

To be sure, a legitimate concern of the judiciary is the protection of the public, but because of the understanable uncomfortableness of the judiciary with the abstract nature of mental illness, this concern for public safety may often preempt precise consideration of the mental condition of the individual before the court. Also, although committing judges are allowed broad discretion, they are quick to defer to mental health officials or "authorities," essentially out of their reluctance to involve themselves in the thorny issues attending mental commitments. Similarly, appellate courts are hesitant to review prerogatives under state commitment codes, and generally have deferred to decisions of committing judges (a procedure analogous to deference paid to administrative tribunals by review courts).

Despite severe diagnostic problems, especially in making determinations of dangerousness, such determinations are made and people are consequently committed to mental health institutions. From the standpoint of security—particularly that which is involved in protecting the public—the type of institution in which a mentally ill person is confined, in light of the developing law, may make a substantial difference.

The Right to Treatment

Recent modification in New York statutory law pertaining to mental health commitments has focused public attention on the transfer of supposedly "dangerously mentally ill" individuals from Department of Correction facilities to those under the jurisdiction of the Department of Mental Hygiene. In *Mtr. of Kesselbrenner* v. *Anonymous* [33 N.Y. 2d 161 (1973)], the case which provided the impetus for these statutory changes, the Court of Appeals indicated that, under the Constitution, where it is thought appropriate to confine someone due to his alleged mental illness, that confinement must not infringe upon the patient's personal freedom more than absolutely necessary to realize the purpose of his commitment. Essentially, what this has meant, is that a number of mentally ill individuals who had been confined in penal (New York Department of Correction) facilities where the emphasis has been institutional security, have been shifted to civil institutions where the emphasis ostensibly has been treatment. Hence, treatment has become a key concept in a significant expansion of the rights of the involuntarily committed mentally ill and in the associated circumscription of the institutional security to which these individuals may be legally subject.

To facilitate an overview evaluation of the right to treatment, two classes of persons confined as mentally ill are herein considered:

1. Those whose commitments are based upon criminal conviction; and
2. Those whose commitments are predicated upon something other than a criminal conviction (including, for purposes of this analysis, persons who have been acquitted by reason of insanity; persons who have been indicted but found incompetent to stand trial; persons whose criminal sentences have expired but are nevertheless retained as being mentally ill; and persons otherwise committed under either *parens patriae* or the police power).

The former may be referred to as the "criminally mentally ill," and the latter are the civilly committed.

There have been recent decisions which have had a broadening impact on the rights of the civilly committed. In *Rouse* v. *Cameron* [373 F. 2d 451 (D.C. Cir. 1966)], the United States Court of Appeals held that based upon a District of Columbia statute, persons committed to a mental hospital after having been acquitted by reason of insanity have a right to treatment. The court intimated that absent a statutorily prescribed right to treatment, there may be a constitutional basis for such a right.

A constitutional basis for a right to treatment was found in *Wyatt* v. *Stickney* [325 F. Supp. 781 (M.D. Ala. 1971)], where it was held that under the due process clause, involuntarily committed civil patients have a right to treament which accords each patient a realistic opportunity to be cured or to improve his mental condition. The *Wyatt* court said:

> "To deprive any citizen of his or her liberty upon the alturistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process."

Although the emphasis on the "therapeutic" basis for commitment in the *Wyatt* rationale might appear to make a due process right to treatment available only to those committed under *parens patriae*, where the underlying justification is the well-being of the patient, such a right to treatment may also apply to persons committed pursuant to the state's police power.

The United States Court of Appeals in *Donaldson* v. *O'Connor* [no. 73-1843, slip op. at 3150-52 (5th Cir. Apr. 26, 1974), cert. granted U.S. Sup. Ct. 1], reaffirming the *Wyatt* rationale, indicated that the right to treatment is applicable to both police power and *parens patriae*

patients on the basis of "central limitations on the government's power to detain."

As has been noted, the general rationale for police power commitments is that confinement of an individual is necessary because he is potentially dangerous to the public. Insofar as commitment entails a substantial deprivation of fundamental rights, the state must provide justification for using such an extreme measure (involuntary commitment) even in furtherance of a legitimate state interest (protection of society).

The Least Restrictive Alternative Doctrine

Recently, the New York Court of Appeals in *Kesselbrenner* [*supra*], in a strongly worded opinion indicated that the least restrictive alternative doctrine applies to civilly committed mentally patients, the court held:

> "To subject a person to a greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined is, it is clear, violative of due process."

In applying the least restrictive alternative doctrine, the *Kesselbrenner* court found a constitutionally based right to treatment for civil patients involuntarily committed. As noted, *Kesselbrenner* applied to patients whose commitments were not based on a criminal charge or conviction. However, the New York State Legislature, correctly concluding that the rationale of *Kesselbrenner* would inevitably extend to those persons whose commitments were predicated on a criminal charge, passed statutory amendments requiring that all mental patients who had not been committed pursuant to a conviction for a crime, be confined only in Department of Mental Hygiene facilities thereby theoretically affording them the right to treatment contemplated in *Kesselbrenner* (see N.Y.M.H.L. §1503).

In *Lake* v. *Cameron* [364 F. 2d 657 (D.C. Cir. 1967)] the United States Court of Appeals held that a court undertaking to commit an individual as mentally ill must consider alternative courses of treatment and must apply the least restrictive treatment consistent with the needs of the patient and society. In a subsequent decision [*Covington* v. *Harris*, 419 F. 2d 617 (D.C. Cir. 1969)], reaffirming *Lake*, the court held:

> "The principal of the least restrictive alternative consistent with the legitimate purpose of commitment inheres in the very nature of civil commitment, which entails an extraordinary deprivation of liberty * * * a statute sanctioning such a drastic curtailment of the rights of citizens must be narrowly even grudgingly, construed in order to avoid deprivations of liberty without due process of law."

Part of the scheme of review which these decisions would require of a committing court, is consideration of whether out-patient treatment may be appropriate. (See N.Y.M.H.L. §31.27.)

The Developing Law and Institutional Security

Of course, if a mentally ill person is not confined, consideration of institutional security becomes irrelevant, at least as it concerns that individual. Commentators who have suggested that out-patient treatment, as an alternative to commitment, should be accorded to more of the mentally ill, have stressed the continuing inability to accurately diagnose or predict dangerousness and the asserted adverse impact of confinement on effective therapy.

The persisting problems which have been encountered in making accurate determinations of dangerousness have been indicated. It has become the "conventional wisdom" among critics of the mental health commitment system that characterizations of mentally ill individuals as "dangerous" have exceeded actual incidences of dangerous propensities. However, it is also true that there are mentally ill individuals in fact dangerous either to themselves or others.

Critics of institutionalization contend that confinement in and of itself is adverse to effective therapeutic processes and that, therefore, absent strong indications of dangerous propensities, a mentally ill person should not be confined.

However, security is not necessarily inimical to the interests of mental patients. Courts have held that governmental institutions to which persons are committed for care or custody have a responsibility to reasonably protect the safety of these persons. Particularly with regard to mental health institutions, security is essential to promote an atmosphere conducive to productive therapy.

Also, we believe it possible to design an institutional security system which can reconcile the interests of patients for whom maximum-security may not be necessary, as well as the interest of security personnel in maintaining proper supervision of persons for whom it is appropriate. Essentially, what this requires is a multi-level security capability whereby there would be maximum-security around the periphery of the institution and varying degrees of sector security within the institution. By effecting such a system, mental health professionals would have an opportunity to closely observe a patient's adaption to phased doses of freedom within the institution. Decisions to release for out-patient treatment an individual who had been initially designated as "dangerously mentally ill" could then be based upon direct, professional observation and evaluation of that person's ability to respond to personal freedom without manifesting dangerous, or self-destructive tendencies.

We recognize the fact that it is difficult to simulate, within any institutional environment, the conditions with which a mental patient

will have to cope, if released. However, psychiatric professionals should be able to garner important diagnostic data by monitoring a confined patient's reaction to freedom which may be practically accorded him pursuant to the suggested phased peripheral security capability.

The Secure Ward: Legal Constraints

To achieve such a capability, the institution may develop a ward or sector system whereby the nature and extent of intra-facility confinement may vary (such as the I.C. ward system at the Bronx Psychiatric Center).

However, in *Williams* v. *Robinson* [432 F. 2d 637 (D.C. Cir. 1970)], cited in *Kesselbrenner* [*supra*], a two-judge panel for the Federal Court of Appeals, held that a mental patient, who had been accused of robbing and threatening another patient, could not be transferred to and confined in—beyond the need for immediate action—a maximum security ward without a hearing. The court noted that the place and manner of confinement of a patient within a hospital facility is generally within the broad discretion of the hospital administration. However, the judiciary retains the prerogative to review the permissibleness and reasonableness of such a decision. The hospital must show the information upon which it relied and, where the decision turned on a disputed issue of fact, whether the patient was accorded an opportunity to tell his side of the story. The court indicated that the hospital may provide hearing procedures on an *ad hoc* basis as long as they are clearly specified in the record, but hinted strongly that it would be advisable, in the interests of facilitating and limiting judicial review, for the hospital to establish hearing "mechanisms."

The *Williams* v. *Robinson* decision noted that in reviewing the transfer of a mental patient from a less restrictive ward to a more restrictive ward, the hospital will be bound by the information contained in the record on which it ostensibly relied in making its decision. Hence, the keeping of comprehensive hospital records will probably help preserve for the hospital the full measure of its administrative discretion, while also promoting a more careful consideration of the interests of the patient.

Conclusion

The dilemma confronting the Courts and the Legislature is how to adequately protect the community against mentally ill individuals who may be potentially dangerous while effectively safeguarding the procedural and substantive rights of patients. This review of relevant legal issues does not pretend to suggest solutions, but rather to provide a broad conceptual framework for consideration of the investigative report which follows: However, perhaps it will be useful to summarize several important concepts here.

1. It is unclear whether a committing court in New York has the duty, prerogative, or capacity to consider alternatives to commitment, but the *Kesselbrenner* decision would seen to have established in New York a constitutionally based right to treatment for all civilly committed mentally ill. (See N.Y.M.H.L. §15.03.)

2. Although a suggested phased peripheral security system may help ameliorate the apparent dichotomy between protection of the public against the "dangerously" mentally ill and protection of the rights of the patients, careful attention must be given to the severe diagnostic difficulties attending determinations of "dangerousness" as well as to the due process rights of patients *vis-a-vis* commitment to a so-called "I.C." or "secured" ward.

3. Whether or not it will be ultimately established that convicted criminals who are mentally ill have a constitutionally based right to treatment, New York should establish such a right legislatively. The

"warehousing" of the mentally ill—be they criminal or not—makes as much sense as witch hunts.

It is recommended that a right to treatment for *all* mentally ill individuals be legislatively established, and that all mentally ill individuals for whom commitment is thought appropriate, should be confined at institutions which have a phased peripheral security capability.

2. Security Facilities of the Bronx Psychiatric Center

a. Open-door Policy

For several years prior to the inception of this investigation almost all of the State Department of Mental Hygiene's mental hospitals, including Bronx State Hospital, were, under the administration of the commissioner, open-door institutions: that is to say, the ward doors in these hospitals were left open and unguarded for selected periods of time during the day. The majority of these hospital's patients were therefore free to walk out of their facility at virtually any time.

Perhaps the Department of Mental Hygiene's open-door policy may be explained as being the product of overreaction by some members of the psychiatric profession to the dismal failure of Matteawan State Hospital (a correctional facility for the mentally ill). Observing that the locked doors, fences, barbed wire, guards, and detention cells of Matteawan had served to foster a custodial rather than treatment orientation on the part of that facility's personnel psychiatric experts opted in years past to reject the notion of security in civil mental hospitals. Specifically, it was believed that the locking of ward doors in a civil institution would inexorably lead to other more restrictive security measures creating the same prison-like atmosphere that pervaded Matteawan and made it—in the final analysis—the virtual warehouse for the mentally ill it was. A residual effect of the

Matteawan experience, in other words, was that "security" in a number of psychiatric circles became almost synonymous with "custody" and "open-door" with "treatment".

Yet, there were those both in and out of the profession of psychiatry who disapproved of the open-door concept. Some felt that the policy was partially the product of laziness on the part of hospital administrators and employees: it's obviously simpler to leave ward doors open than to carefully supervise the patient, employee and visitor flow into and out of wards. Others claimed that the open door, a symbol of absolute trust shown by hospital authorities to the patients, could not be readily accepted by those patients who, because of the severity of their illness, had not been permitted free access to the outside world. The abrupt change from closed surroundings to open wards did not, some believed, allow patients the time they would need to adjust through gradual doses of trust. Thus, many formerly confined patients abused the sudden confidence shown in them, by escaping, experts claimed. Still other experts, it is noted, asserted that complete openness meant a loss of the type of diversity and flexibility needed to provide optional treatment to a varied patient population.

Notwithstanding, the sentiments which had been expressed by psychiatrists and department officials concerning the pros and cons of the open-door policy, however, it became apparent that the Department of Mental Hygiene would be required, following the enactment of the Criminal Procedure Law in September, 1971, to provide secure facilities for the hospitalization of accused but unconvicted mentally incompetent defendants. (The Criminal Procedure Law, in effect, gives to the Commissioner of Mental Hygiene the responsibility of holding incompetent defendants until recovery, at which time the defendants are to be returned to the criminal justice system. Unlike a misdemeanant's charges which are dismissed upon an adjudication of incompetency under the CPL, the felon's criminal action is suspended

during the term of the Temporary Order of Observation [if found incompetent before indictment] or during the term of the Order of Commitment [if found incompetent after indictment].)

The Department accordingly established Mid-Hudson Psychiatric Center, a secure facility for the housing of a large proportion of those unindicted non-dangerous felons who would thereafter be adjudicated incompetent under the new law.

The Department did not, however, modify the security policies it employed in the other state hospitals under its control. Defendants under the jurisdiction of the Department designated to catchment area hospitals were consequently lumped together administratively and in fact physically with the civil patient population of the hospital. And ward doors remained open.*

1. Recommendations Relative to the Selective Open-Door Policy: a Forensic Unit

The doors of Bronx State Hospital (now Bronx Psychiatric Center) were opened in 1967. It was hoped that it could remedy in the patient incarceration in the then closed wards. Disruptive patients had been transferred to locked wards and virtually forgotten. After 1967, with the exception of patients in the Lincoln Unit Intensive Care Ward, almost all the hospital's patients, whether voluntary or involuntary, were free to leave at any time they chose. There were no locks on the doors of the wards, no locks, guards or check points at the exits and entrances of the buildings, and no gates, fences, or walls anywhere on the grounds.

* A tragic example of what can happen when a mental hospital maintains an open door policy is the recent case of Richardo S. Caputo. Mr. Caputo had been in Matteawan State Hospital prior to being trnsferred to Kirby-Manhattan Psychiatric Center on Ward's Island. He walked out of the Ward's Island Hospital and allegedly killed a psychologist with whom he had made friends while he was incarcerated at Matteawan.

This continued for some time, until changes in the law made it inevitable that the hospital would have to house larger and larger numbers of assaultive and aggressive civil patients. Because of limited intensive care bed space, many criminally dangerous patients who had theretofore been housed in the hospital's only truly locked ward were then administratively transferred or "bumped" out of that ward, the I.C. Ward, and into the open geographic wards to make room for other more severely disturbed patients (both civilly and criminally committed). Since the geographic wards were (and still are to some extent) run by the therapist aides—untrained to deal with the dangerously ill and criminally committed—patients escaped, causing public outcery and reaction by state and local officials.

In response, on July 9, 1974, the director of the Bronx Center ended the open-door policy and instituted a "selective open-door policy". Pursuant to this new policy all ward doors are locked, but off-ward activities (in the rehabilitation building and elsewhere) are permitted for patients who are amenable to such activities and for whom such activities contribute to a therapeutic plan. On-ward activities are therefore now designed for those patients who are determined by professionals to lack sufficient integration to participate in off-ward activities. Patients leaving the ward, moreover, carry honor cards: small cards which indicate the purpose for which the patient was permitted to leave his or her ward.

The selective open-door policy has been effective in reducing the number of elopements, *i.e.*, escapes from the institution. In a memorandum dated August 20, 1974, the director reported that leaves without consent were dramatically reduced between June and August, 1974. In June, 135 different patients eloped, according to the memo, a total of 177 times. In July, 1974, 51 patients eloped 63 times, a reduction of 62% in the frequency of leaves without consent, *i.e.*, number of escapes. These percentages remained the same in the second full month during which the policy was in effect.

The selective open-door policy is apparently necessary and appropriate for the majority of the patients at the Bronx Psychiatric Center.

Although successful in reducing the number of patients escaping and the frequency of escapes, the selective open-door policy has nonetheless had negative ramifications regarding patients committed pursuant to Articles 730 and 330 of the Criminal Procedure Law. Article 730 sets forth criteria for determining whether a defendant has sufficient mental capacity to proceed to trial, and procedures for the commitment of a defendant who is designated an "incapacitated person". Article 330 pertains to the commitment or release of a defendant acquitted on the ground of mental disease or defect. Formerly, these patients were housed, as other civil patients, on the geographic wards. If dangerously ill they would be designated to an I.C. unit. If not, they would be free as all other patients to leave the ward in which they were hospitalized. Because of the concern expressed in many sectors over the escape of patients with criminal charges pending, the hospital not only closed ward doors but restricted all Article 730 patients to their wards as well. Consequently, all Article 730 patients remain behind, while civil patients on the same wards are free, subject to hospital regulations and procedures, to leave the wards under escort or otherwise and attend treatment activities. Some civil patients depart for overnight or weekend home visits. Articles 730 and 330 patients on the other hand are prohibited from leaving the hospital.

These criminally committed patients, many having at best minimal contact with reality, find it extremely difficult to understand why they are being overtly discriminated against in this fashion. Some become openly hostile; others become confused and despondent. In addition to being deprived of a number of therapeutic activities available to others, Article 730 patients have obviously been psychologically harmed by the very deprivation of their freedom.

The following action is therefore recommended:

A forensic ward or unit should be established to house all Article 730 and 330 patients who are not considered "dangerous" to themselves or others. (Dangerously ill patients are and should continue to be housed in the I.C. unit). All non-dangerous Article 730 patients will then be housed in these wards or in this unit, for their entire stay at the hospital, regardless of geographic catchment area. All patients in the forensic ward or unit will receive the equivalent care and treatment afforded all other patients in the hospital. The ward or unit, moreover, need not be made any more secure than any other geographic ward of the hospital. The mere fact that these patients will be in one area of the hospital, as explained *infra*, will create a condition less conducive to escape.

The following are the advantages of such a forensic unit:

(1) With a separate forensic unit, 730 patients may be located administratively with relative ease.

Prior to our investigation a patient's records did not adequately indicate patient status, *i.e.*, whether or not he had been committed pursuant to Article 730 or 330. Many 730 or 330 patients therefore got lost in the shuffle, so to speak, for varying periods of time. Some, perhaps, were even able to escape because staff were unaware of the charges and allowed the patient to wander off or even go home for a weekend, only to discover later that the patient was a 730 or 330 commitment. All charts of those on the forensic ward should be color coded to assure lack of administrative blunders, and be kept in one filing area, readily accessible to staff, who in turn will be then able to quickly provide the court, the district attorney or some other appropriate individual with properly disclosable information concerning the patient.

(2) Article 330 or 730 patients will accordingly not feel as though they are being discriminated against since all patients of an

equivalent mental status will have available to them the same treatment opportunities.

(3) As a group, 730 and 330 patients can be easily surveilled by personnel.

With only one or two 730 patients on a ward staff must be divided so that there is sufficient coverage in the ward at all times. Civil patients who must be escorted to facilities may sometimes be deprived of treatment for lack of personnel. When all 730 and 330 patients are on one ward, such division of ward staff need not occur.

(4) With a forensic ward, off-ward activities will become available to 730 patients.

It is not advocated that all 730 patients be perpetually locked in their wards. Those patients, sufficiently integrated to participate in activities, should be permitted access to them under close supervision. To accomplish this, the following is suggested:

(a) At designated times, hospital treatment facilities outside wards should be made available to patients from the forensic wards or unit.

(b) A security bus or car should be provided for transportation of forensic patients to the various areas of the hospital where treatment is provided. (These recommendations only pertain to facilities which are capable of being secured. Programs which must be conducted in the outdoors or in an area which cannot be adequately patrolled by hospital personnel should not be made available to 730 patients because of the security risk involved).

(c) Patients, under the watchful eye of an adequate complement of security officers and ward personnel, should then

be escorted from the ward, into the awaiting vehicle and to the treatment activity or program.

(d) After accompanying patients to the area where the activity or treatment program is conducted, security and ward personnel should remain posted at strategic spots so as to prevent patients from escaping.

(e) During the hours that the treatment facility is being used by forensic patients (and the time of such use should not be announced in advance or be a matter of routine) all other patients should be restricted from the area. (This deprivation is minimal and will, it may be expected, have no appreciable therapeutic effect on the civil patient population). Exit doors of the rehabilitation building should be locked and guarded by security or ward personnel.

(f) When the activity or program has been completed security and ward personnel should escort the patients back to the ward in the same manner patients were transported to the activity.

b. The Intensive Care Unit

The intensive care unit of Bronx Psychiatric Center is a special unit for the care and treatment of the assaultive, suicidal or aggressive patients of the hospital. Continually troublesome patients are transferred to Mid-Hudson.

History

After locked wards were ended at Bronx State Hospital in 1967, it became apparent that not all types of patients could be treated in such an open milieu. For those who demonstrated serious difficulties in controlling their impulses, the hospital required some way of dealing with them, some way of helping them by providing the internal

controls they lacked and the security they required. Thus, in 1970, the staff of the hospital's Lincoln service unit—a unit having at the time a 225 bed service for 350,000 residents of the South Bronx—established an intensive care ward, with an extremely limited census. The plan was (and indeed its actual function now is) to provide quality care to seriously suicidal, aggressive and uncontrollably agitated patients on an acute, short-term, crisis-intervention basis. All modalities of treatment were to be made available. The closed door would assure that the patient received what was prescribed and also serve other needs.

Facility and Functions

Originally the intensive care service was provided on ward 6 which had only one locked door. In November of 1972, the ward was reopened as a unit and its chief had a second locked door installed. The I.C. unit, having 15 beds, was thereafter used not only for patients in the Lincoln service unit but for patients from all other hospital services as well.

The unit now consists of two wards, six and eight, on the third floor of the Parker Building (building 102).

At the entrance to that section of the Parker Building in which wards 6 and 8 are located, is the first of three locked doors that one must pass through before one is inside the patient area. The hallway door is opened by a ward attendant who is summoned by a ringing of a buzzer, the button to which is located at the entranceway. The attendant, after learning the visitor's identity, will permit the individual admittance. One must then walk down a short passageway, stop at an office serving as an information area or visitor's checkpoint, and there, present the visitor's card which one had obtained earlier at the downstairs information desk. The visitor next is escorted through a second locked door which has both a state hospital turnkey lock and a separate turnbolt lock. One walks through a short hallway

and encounters the third and last double locked door which opens into the ward.

The wards themselves, each with a census of 15, house both male and female patients in separate dormitories which are left unlocked at night and are locked during the day while patients are in the dayroom or undergoing therapy. Since no patient is permitted to leave the ward for any purpose other than medical care, all treatment is provided on the ward. When patients must leave, they are escorted, in handcuffs, by a security officer.

Staff

The intensive care staff consists of only one psychiatrist, a psychologist, a social worker, an occupational therapist, a recreational therapist and a number of nurses and nurse attendants or therapist aides. These therapist aides are state civil service employees and thus make about $9,000 a year. They receive the same training all other therapist aides in the hospital receive. The unit chief, however, is in the process of developing a special training program which may be available in the near future to I.C. unit staff members.

Intensive care staff members suffer the highest number of patient caused bodily injuries of all hospital employees. Since 1972, 976 man hours have been lost by the I.C. unit workers because of injuries inflicted by violent patients.

Patients Referable

All assaultive or suicidal patients on other hospital wards are referred to the intensive care unit where they are screened by the unit's staff to determine suitability for transfer there for short term treatment.

In addition to this group of patients which includes both civil patients and those committed under Articles 730 and 330 of the CPL,

all patients committed pursuant to Article 730 are first designated to the I.C. unit for at least a brief period of evaluation. If the 730 patient is diagnosed as being dangerous to himself or others he will be kept on the ward until stabilized on medication. If not diagnosed as being dangerous, the patient will be transferred to the geographic ward noted at the time of admission upon his admission papers for administrative reasons only.

Treatment

Patients are stabilized on medication prescribed after an extensive diagnostic investigation has been completed. Patients are thereafter subjected to a full psychiatric screening and undergo intensive group and occupational therapy, participate in recreational, dance and music therapy, and view movies once a week. Patients are permitted to make phone calls as often as they wish, providing, however, they do not harass the person they call. If a patient is extremely disturbed a staff member will dial the number and ask if the receiving party desires to accept the call. Smoking is prohibited in dormitories. All matches have been eliminated on the wards.

Once elopement prone or aggressive patients have established good contact with reality and have a verbal and behavioral awareness of their illness and need for hospital treatment, they are returned to their geographic ward.

The average stay on the ward is about two to three weeks.

1. Recommendations Relative to the Intensive Care Unit

The intensive care unit is not large enough in terms of bed space to treat all the assaultive civilly and criminally committed patients, and to evaluate all criminal commitments. Nor is the psychiatric staff large enough to allow for intensive psychiatric care of all patients housed on the ward. When the unit chief leaves the ward to attend

conferences there is no psychiatrist left on the ward to handle emergencies.

There are times when a patient housed in the I.C. unit must be "bumped" off the unit onto regular geographic wards so as to provide a bed for some patient in greater immediate need of intensive care. Oftentimes the patient "bumped" is one who may still be considered "dangerous" to himself or others. The resulting situation, namely, dangerous patients on geographic wards, is obviously undesirable.

It is therefore recommended that a substantial number of additional beds be converted for intensive care purposes and that a commensurate complement of professional and para-professional staff be assigned to the unit.

It is also clear that the hospital admissions office fails at times to attach an admissions note to the chart of a patient who has been committed pursuant to Article 730 or 330. This failure to properly identify criminally committed patients subsequently creates an unsafe condition when patients are transferred from the intensive care unit. The staff of the geographic ward to which the patient has been transferred, unaware that the patient has criminal charges pending, may allow the patient to leave the ward and thus escape. To prevent such occurrences in the future it is suggested that all criminally committed patients' charts be color coded to distinguish them from charts of the civilly committed.

There are two other difficulties associated with the intensive care unit. First, the turnkey lock on the ward doors are of the type found throughout the hospital. Many hospital employees carry these keys, which obviously may be lost or become accessible to patients. It is suggested that these turnbolt locks be replaced with other types of locking devices, the keys to which will be carefully inventoried and will be returned by employees at the end of each shift. Second, instructions as to whether a patient being transported from the I.C. unit will be

handcuffed or not are usually relayed to security officers through ward attendants. This practice should be discontinued. Attendants may, on occasion, take it upon themselves to usurp the power of the psychiatrist and assert that the psychiatrist had ordered the imposition of this security measure. It is recommended that a system be established which permits the psychiatrist to communicate the order for handcuffs directly to the security department.

c. Grounds and Buildings

After having toured the Bronx Psychiatric Center in August, 1974, it is apparent that the hospital, in general, employs far fewer security measures than does the average American college or university. The grounds are totally unfenced (other than by the Hutchinson River Parkway) and buildings are totally open during the day. Entrances to buildings as well as to the grounds themselves are unguarded by security personnel of any kind. Elevators in most instances are left unlocked and unattended. Almost anyone, therefore, is able to enter upon the hospital grounds, walk into a hospital building and ride in an elevator up to the ward area, without challenge or observation. (There were, to be sure, security officers on duty at the time the hospital was viewed during this investigation, but few were to be seen other than at the administration building).

1. Recommendations Relative to Grounds and Buildings

The lack of control over who enters or leaves the hospital has been a major contributory factor in a number of crimes committed on the hospital's grounds. Unpatrolled by city police and too large to be guarded by the woefully inadequate security force (see discussion pp. 55 *et seq.*) that the hospital grounds have become a potential haven for muggers, rapists and thieves.

Once a patient gains freedom from his ward he is able to leave the hospital entirely. There is no person or thing to stop him, or even to impede slightly his efforts to depart.

It is recommended:

1. That a chain link or slat fence be built around the institution's grounds.
2. That security officers be posted at guard houses established at entranceways into and exits from the hospital grounds.
3. That at the very least some observation, electronic or otherwise, be made of persons entering into and exiting from hospital patient buildings.
4. That security guards be on constant, uninterrupted patrol of hospital grounds.

3. Security Practices, Procedures and Personnel

a. Safety Officers

The security force of the hospital consists of safety officers who have been formally trained for a total of two weeks at the Safety Officers Training Academy at Montour Falls, New York. Their training consists of lectures and demonstrations by state police representatives, Department of Mental Hygiene personnel management employees and Department of Mental Hygiene, Division of Fire Safety Officials, who teach self-defense techniques, the handling of fire safety apparatus, fire safety procedures and the keeping of hospital safety records.

The Bronx Psychiatric Center has a chief safety officer who is charged with making out the duty sheets and maintaining the safety docket book. Officers are supposed to make rounds about once every hour but while the chief safety officer is away or off duty there is no one on the grounds to supervise.

The officers have walkie-talkies, employ one patrol car which has a siren and alley light, but they do not carry handguns or other weapons.

There are supposed to be 3 or 4 security officers on every shift. But because of vacations or absenteeism there are, at times, only one, two or three men on duty to cover the entire 113 acre hospital complex.

Frequently, there is no one in the security office, since all officers on duty are either on patrol or aiding ward personnel with a problem patient, or performing some other security function. Calls for assistance from within the hospital, therefore, go unheeded on occasion for lengthy periods. Such a situation may eventually lead to death or serious injury at the hospital.

1. Recommendations Relative to Security Officers

Although the Department of Mental Hygiene has recently added another 13 security officers to the hospital making the present total 27, it still appears that the number will be inadequate to maintain safe conditions in the hospital, situated as it is in one of the highest crime areas of the city. Furthermore, there is a substantial amount of time spent by security officers in doing clerical work, *i.e.*, incident reports, theft reports, fire reports, and in carrying out non-crime prevention or enforcement functions, *i.e.*, fire prevention and extinguishment. The security force as presently constituted is thus not able to devote sufficient time to hospital security functions.

It is recommended that there be a substantial increase in the number of security officer positions at the hospital so as to provide enough staff to cover the security office and maintain constant patrol of the hospital's grounds at the same time. It is also recommended that the increase in the number of safety officers not cause a proportionate reduction in the number of ward personnel employed by the hospital. Ward attendants serve a valid security function by watching patients. Reduction in the number of this category of worker will merely leave the hospital in the same security position it was in before the increase in the safety officer staff.

There is a need for greater mobility of the security force. It is recommended, therefore, that additional vehicles be employed by the hospital for security functions.

Several other factors have combined to reduce the efficiency of the security force: lack of supervision in the absence of the chief, lack of appropriate training, and lack of efficient communication between the security office and other sectors of the hospital concerning safety practices.

It is therefore recommended (1) that the appointment of supervisors to fill the 3 positions recently made available by the department, be accomplished forthwith; and (2) that a comprehensive in-hospital training program for safety officers be established and maintained; (3) and that lines of communication between the security office and other sectors of the hospital, *i.e.*, the departmental offices and the administration, be established and maintained to assure complete dissemination of information concerning safety practices in the hospital.

b. Ward Personnel

1. Recommendations Relative to Security Function of Ward Attendants

Most administrative control over wards lies in the hands of the ward charge who is usually either a nurse or a therapist aide: an individual who may or may not have any of the requisite skills needed to be able to properly coordinate, motivate, and evaluate the performance of both professional and para-professional hospital employees. Yet, in many instances, this is precisely what the ward charge's function is. Although the specific lines of authority seem to vary from unit to unit according to whether there is a supervising nurse and according to the roles that the team leader and unit chief play, it is evident that responsibility for ward assignments, the scheduling of working hours for attendants, and general supervision of activities is

given as a matter of course to the ward charge or someone designated by that person. As ward employees leave because of resignation, retirement or dismissal, lines of ward authority sometimes shift. A supervising nurse may quit and an attendant is left in charge. A nurse may be transferred and take over in her new ward as the charge. But because procedures and chains of command vary, it takes some time for the new person to adjust: to learn the new procedures and the new chain of command. During that period of adjustment or simply because the ward charge is not capable of handling the responsibility, administrative snafus can and do occur: individual employees are unassigned, misassigned, or are simply allowed to go home before their shift has ended. All of this contributes to a general laxity in the observance of proper procedure, both clinical, and security. Escapes, therefore, occur.

What's more, although Bronx Psychiatric Center attendants are relatively well trained for clinical functions, it is clear from the number of escapes and from fires at the hospital—that their training in regard to safety and security practices is less than acceptable. It is recommended, therefore, that the following actions be taken:

1. Ward charges should be appointed only after careful, extensive screening and testing to assure they are capable of handling the responsibility of that position.
2. Ward charges should be required to pass an in-hospital examination concerning all ward security and safety practices and procedures.
3. A pamphlet should be compiled containing an explanation of all hospital security and safety practices and procedures for use of ward charges and other hospital personnel.
4. All persons acting as ward charges should be formally re-evaluated periodically by the appropriate unit chief to insure fitness for ward charge positions.

5. Ward authority structures should be clearly defined, recorded and as documented, disseminated throughout the hospital.
6. In addition to ward charges, all staff personnel, including professionals, should be required to know all safety and security practices and procedures and should be periodically tested to assure comprehension of them. The former autonomy of service units, and the former lack of policy guidelines from the hospital's administration, resulted, in some instances, in a dearth of understanding by staff members of the procedures to be employed for criminally committed patients. All procedures should now be compiled in a single pamphlet and distributed to all staff members who should be required to know them. (Of course, with a forensic ward, as that suggested on pp. 47 *et seq.*, only members of that ward or unit need be familiar with the data). This same format should be followed for security and safety practices in general (all essential information is already in the Policy Manual).
7. In addition to ward charges, all ward personnel, including professionals, should periodically be formally evaluated for general competence in their individual positions, by unit chiefs or an appropriate designee of the unit chief.
8. Each unit should have a safety and security administrator responsible for seeing that all safety and security practices and procedures are understood and followed on each ward by all staff and for seeing that the unit personnel is fully aware of the practices and procedures employed for patients committed under Articles 730 and 330.

Once a forensic ward (see pp. 47-49) is established, only staff of that ward and of the I. C. unit need be required to know all 730 and 330 procedures.

c. Escape Reporting

Examination of hospital memoranda show that the following was, prior to this investigation, the hospital's procedure for the reporting of escapes:

1. Security office in hospital must be notified: thorough search of buildings and grounds must be made by ward staff and safety.
2. Hospital authority (ward doctor or charge) will make notification to family or friends or guardian agency of disappearance of patient.
3. After a lapse of a reasonable period of time (depending on diagnosis and condition of patient or type of hospital retention) the doctor or ward charge will notify the 43rd Police Precinct (phone TA 8-7474). Court cases, dangerous patients and Matteawan patients must be reported without delay, court and D. A. to be notified.
4. If ward has knowledge of location of patient, *i.e.*, house or other location, this must be included in the report.

   If patient returns call the 43rd Police Precinct to inform them in order for the search to be terminated.
5. Police precinct will accept report on missing persons on:
   (a) court committed patients and Matteawan patients.
   (b) 2 P. C. commitment cases.
   (c) Voluntary patients who evidence dangerous traits to themselves or others.

As a result of recent conferences between the hospital, the police and the District Attorney, the hospital will no longer wait a reasonable period of time before reporting an escape to the proper authorities. Moreover, contrary to previous practice, escape of all dangerous patients and those committed pursuant to the Criminal Procedure Law will be reported to the 43rd Precinct for immediate action. Escape of non-dangerous voluntary patients will be reported to the family of the patient only and involuntarily committed non-dangerous patients and voluntary patients who escape will be referred, if reported to the 43rd Precinct, to the Missing Persons Bureau.

The hospital indicates on its own records the elopement of a patient by either marking the patient's papers "leave without consent" or "escape," according to the status of the patient at the time of the escape. For example, if the patient was last considered dangerous to himself or others he will remain on escape status and will therefore be reported as an "escapee" rather than as a missing person. All persons committed under an Article 730 Temporary Order of Observation or Order of Commitment or Retention will be left on "escapee" status when they leave without consent. If confined in the hospital on an Order of Observation and then escapes the patient's papers are marked "escape" until the end of the 30 day period provided by statute for the examination, at which time the patient's papers are marked "discharged." All those on a Final Order of Observation who elope are discharged unless dangerous, in which event they are considered escapees and are reported to the police as such.

In addition to the new reporting procedures by which the hospital contacts the police, the 43rd Precinct itself calls the hospital every day to check with the Center's operator who keeps a log by his or her side to record all admissions and escapes.

This present reporting system is a good one and should be continued.

1. Recommendations Relative to Escape Reporting

There appears to be some confusion created by the classification of patients in hospital memoranda explaining the reporting procedures to be employed. The words used are "voluntary," "Matteawan

patient," "dangerous patients," "court case" and "two physician certified."

"Voluntary" is clear enough. It is unclear, however, why there is some distinction drawn in the memos between "Matteawan" and "dangerous patients." If a patient is no longer considered dangerous to himself or others and has been criminally committed, he no longer need be referred to as a Matteawan patient, only criminally committed, dangerous, or court case. (Transferees from Mid-Hudson theoretically could be equally as dangerous as Matteawan tranferees but are not referred to as Mid-Hudson patients). Reference to some patients as Matteawan patients, when in fact they are "dangerous" and are court cases, is the drawing of a distinction without a difference. The mere fact a patient has been transferred from Matteawan should not be a basis for classifying him differently unless he is considered dangerous, in which event he should be classified as "dangerous." The additional category entitled "Matteawan" consequently creates confusion and should be eliminated. (Use of the words "dangerously incapacitated" and "Matteawan" will slowly become obsolete now that chapter 629 of the Laws of 1974 has eliminated all procedures for the adjudication of dangerousness and the transfer of such patients to Matteawan).

Additionally, "court case" and "two physician certified" seem redundant or at least nebulous, since both criminal and civil patients must be examined by two physicians and be committed or retained by the court.

The wording of hospital memoranda or other documents concerning escape procedures should be:

> Escape of anyone committed pursuant to a court order, be it criminal (which naturally includes an order issued under Article 730) or civil, or anyone considered dangerous to himself

> or others irrespective of the type of commitment, shall be reported to the police immediately.

The sequence of reporting escapes as reflected by hospital documents should also be changed to indicate—once a search of the hospital grounds has been conducted and the appropriate information obtained from the charts of the patient thought to be missing—that the first step to be taken by the hospital employee is to notify the police, not the patient's family. If the patient is subsequently found to have returned home or to a relative's place of residence the police may be notified and the police search will be discontinued.

It is also apparent, as previously indicated (see p. 59) that ward personnel, including psychiatrists, are frequently confused as to the procedures which must be utilized in the event of an elopement. In fact, some do not know their responsibility and thus do not act when they should. Others, unsure of the procedures, waste valuable time by not reporting the escape to the proper authorities.

First, therefore, it is clear that staff must be made acutely aware of the procedures to be followed when reporting escapes. Thus, unit chiefs should be instructed to periodically review reporting procedures with the personnel on their service. Moreover, to make sure that each person on the ward knows his or her responsibility in the event of escape, a large legible chart should be affixed to the wall at the nurses' station indicating who is responsible for what in the event of an escape. In this manner, time is less likely to be lost and mistakes or omissions less likely to occur.

Lastly, it is noted, from the hours of 4:30 p.m. to 8:00 a.m. there is a resident or staff psychiatrist on duty, and from 4:30 p.m. to 10:00 p.m. there is a night administrator in the hospital to handle any problems which may arise during the "off-hours".

From 10:00 p.m. until 8:00 a.m., the night administrator, a member of the hospital's administrative staff (including the director), is on call by either phone or beeper. As of the present time, there has been no allocation made for a permanent administrator.

It is recommended that a permanent administrator be employed. With such a person present on the grounds, the likelihood of delay in the reporting of an escape until the following morning will be reduced.

d. Reporting of Crimes Occurring on the Hospital's Grounds

In instances of crime on the hospital's grounds not involving a state hospital employee or patient, the security department will not report the occurrences to the police but will advise the victim to do so. The security office will, however, attempt to apprehend the suspect if he or she is thought to be somewhere on the grounds. The officer will also fill out a missing property form in the appropriate case.

1. Recommendations Relative to Failure to Report Crimes

In view of the Department of Mental Hygiene's own stated policy (in the Department of Mental Hygiene's Policy Manual) and in the interest of deterring criminal activity at the hospital, the institution should be mandated to report all criminal incidents occurring on the hospital grounds and coming to its attention. Failure to report crimes will simply permit the same perpetrator to return to the grounds of the facility to engage again in criminal activity.

Incidents should be reported regardless of the apparent unwillingness of the complainant to notify the police. If a security officer ascertains a victim is unwilling to report the incident to the police he may relay that information to the Police Department which will then in turn take any action it deems appropriate.

e. Escape Prevention: Problem and Recommendation: Investigation of Causes

Following an elopement, the appropriate hospital authority (usually the ward charge or nursing supervisor) completes an institution incident report describing the occurrence.

If a particular employee seems to be repeatedly involved with escapes by patients, the hospital will conduct an investigation. Even under these circumstances the inquiry is rather informal, consisting of an interview of the employee and review of the incident report.

Clearly, had a thorough investigation been conducted into every escape from the hospital, those security weaknesses which have contributed to the elopements would have been discerned. Patterns of conduct or certain hospital procedures conducive to escape would, in turn, have become apparent. For example, it was learned, but only after numerous incidents over a period of time, that patients were escaping in the following manner: patients would hide behind a ward door just before meal time, waiting for food service helpers to enter the ward pushing their food cart ahead of them. After the cart would pass through the ward door the patient would shove his way out of the ward past the hospital employee, into the building corridor, and then out of the building itself. A thorough investigation of the first such incident would have disclosed the method employed and procedures could have been immediately altered to prevent future elopements in a similar manner.

It is recommended, first, that all hospital procedures be re-evaluated to determine their potential for security weaknesses. Second, a specific procedure should be established at the hospital for the investigation of any and all reported escapes to determine what facility, procedure or employee, or combination thereof, caused them. And third, it is recommended that remedial action be taken concerning any discovered weakness in security caused by an existing clinical or administrative hospital procedure.

C. Fire Safety at the Bronx Psychiatric Center

Prior to December 1972, Bronx State Hospital (now named the Bronx Psychiatric Center) did not have a fire alarm system. On December 4, 1972, the installation of a pull-box alarm system was completed at a cost of $164,120. However, insofar as the pull-box units were readily accessible to everyone, they were vulnerable to being damaged by the patients. Officials at the hospital indicated that patients would pull the units right off the wall exposing electrical wiring.

Patients also triggered many false alarms. To prevent false alarms and the hazard posed by exposed wiring, the alarm system was turned off. During a two year span there were intermittent periods of operation, but as a practical matter, the alarm system was not relied upon by anyone and was essentially useless. The procedure for reporting fires during that period of time was for an employee to telephone the switchboard operator, who in turn would trigger a "class II" alarm unit which is directly lined to the Fire Department.

It was made clear that the Bronx Psychiatric Center had no operative fire alarm system for close to two years, because of a death that occurred after a patient started two fires. The death that occurred in the fire was not caused by the inoperative fire alarm system. It was caused by a patient, who intentionally set another patient's bed on fire. The staff responded to the scene and reported the fire as quickly as possible over the telephone. Unfortunately, it was too late, and the patient died of severe burns.

On April 17, 1974 at about 11:15 p.m., a patient on a ward of the hospital yelled, "fire, a bed is on fire." The staff ran to the room and observed a fire at the foot of a mattress.

The patient in the bed only had small superficial first degree burns on her right ankle and foot. At this time it was assumed that the

fire had been started by the patient while smoking in bed. This was unfortunate since a more thorough investigation at that time may have uncovered the fact that the fire had been set by the patient who yelled fire. Such discovery would have allowed for immediate corrective action and would have avoided the fire and subsequent death on the following day.

On April 18, 1974 at about 12:45 a.m., attendants saw smoke coming from underneath the door of a room and a patient shouted, "I knew it was going to happen." The staff rushed to the room and upon opening the door saw a blazing fire. The room was filled with smoke and the heat was so great that they were unable to get to the patient who was engulfed by flames. The Fire Department and safety office was called and fire extinguishers were used until the firemen arrived. A patient was semiconscious and had burns covering 80% of her body. Resuscitation was attempted and the patient was sent to Jacobi Hospital for burn treatment.

The next morning, Fire Marshals reported to the hospital and proceeded to examine the sites of the fire. After examining the mattresses involved in both fires the Fire Marshals suggested that it was probable that both fires were intentionally started by someone. The fact that a patient was present at both fires and reported both of them, as well as her general behavior made her a suspect. The Fire Marshals were also able to find a fluid cigarette lighter belonging to the patient. After further investigation, the patient was placed under arrest. The patient was later found incompetent to stand trial and committed to the Department of Mental Hygiene under Article 730 of the Criminal Procedure Law.

This case points up flaws in the fire safety system at the Bronx Psychiatric Center. First, patients at Bronx Psychiatric should not be allowed to have matches or cigarette lighters. Second, the entire hospital was without a fire alarm system for close to two years. Fortunately no deaths or injuries can be directly attributable to the lack

of a fire alarm system since fires were reported over the telephone on a special number, extension 2333. However, this does not excuse the failure of the Department of Mental Hygiene for its long delay in making funds available for adequate replacement of the inoperative alarm box system. That system has been replaced with a key box system which is now working but very seldom used by the staff.

On August 29, 1974, a memo was distributed to all staff members concerning the use and operation of the new key operated fire alarm system and the procedure to follow in case a fire or smoke is encountered. The memo is also posted throughout the hospital. However, the system is not being used by the staff. A study was made comparing the fires which took place at Bronx State with the fires reported to the Fire Department for the period of April 17, 1974 to October 23, 1974. During the period of the time there were 60 fires at Bronx State but only 24 of those fires were reported to the Fire Department. It is hospital policy. however, to report every single incident of fire to the Fire Department. This fact points up both the negligence of staff members and the lack of communication between the hospital administration and the staff. Although the administration has set procedures in case of fires they have not made the staff feel obligated to follow those procedures. This condition must be changed.

The Fire Department consistently inspected Bronx State for Fire Code violations and for inadequacies in the fire safety program. During the period that the alarm system was inoperative they recommended that a new system be installed. Many letters were written to the institution where recommendations were made to improve the safety of the patients. On September 10, 1973 a letter was written to Bronx State by the Fire Department which suggested that an alarm system be set which would be directly connected to the Fire Department. The letter also suggested fireproof doors, monthly fire drills and records of those fire drills.

On May 14, 1974, a key box alarm system was finally approved by the Department of Mental Hygiene and it was subsequently installed right over the old pull box system.

The Fire Department inspected the system in early August, 1974, and on August 9, 1974, wrote a letter calling for improvements in the new system. On August 13, 1974, a letter was written to Bronx State from the Fire Department calling for the system to be connected directly to the Fire Department.

On August 13, 1974, a letter was written by the Fire Department in which it was indicated that the system was in working order. The letter also indicated that monthly fire drills were being conducted and records were being kept. It further stated that the hospital's administration was very cooperative and was working on recommendations by the Fire Department to improve fire safety.

However, no matter what procedures the administration makes and no matter how good the recommendations by the Fire Department are, there will be problems if the staff does not follow those procedures and recommendations. An example of that problem occurred on September 16, 1974, when the staff did not follow the procedure of immediately reporting a fire to the Fire Department. Unfortunately, a patient died as a result of that staff mistake.

At 5:00 a.m. on that date a patient was in a dorm room on a ward with three other patients. The patient agitated the other patients by yelling and making noise, so he was taken by the staff and put in a seclusion room where there was only a mattress. There were three staff members on duty on the night shift.

While in the seclusion room, the patient took off his pants, defecated and urinated on the floor, and then set his pants on fire. The staff opened the door and extinguished his burning pants. They did not report this fire at that time or at any other time although they are

required to report any and all fires no matter how small. They searched the patient for matches, except in his jockstrap, and found nothing. The patient was then put in another room so that the seclusion room could be cleaned.

At 6:30 a.m. an aide was taking patients to clean them prior to breakfast. At that time she heard the patient screaming for help and saw smoke coming out of his room. The patient was banging on the door at the time, as the aide tried to unlock the door with her key. It only turned halfway, so another aide also tried her key and was also unable to open the door.

At 6:50 the second aide called the safety office to notify them that there was a fire. The safety officer took a gas mask and went to Ward 16 along with two other officers. They arrived at the ward about a minute later. Upon entering the ward the safety officer saw the aide at the door to the patient's room with her key in the door. The officer told her to get her key out, but it was stuck. He then asked for a screwdriver which the aide brought. He opened the door within a minute.

A second officer put out the fire with an extinguisher. Upon entering the room with the gas mask, the officer found that no patient was present, but a window was broken out.

The incident was witnessed by two employees coming on duty from the outside. A cafeteria worker arrived at work at 6:30 a.m. At 6:39 a.m. she heard glass break. She yelled for help and then saw the patient climb out of the window and hang for about two or three minutes. Then, at about 6:49 a.m. the patient let go and fell to the grass below.

A lock expert from the Safe and Loft Squad removed the lock from the door which would not open. The lock was found to have a side bolt

which was bent because of force applied from the inside. There were also scratch marks on the bolt from the screwdriver the safety officer had used to open the door.

A Fire Marshal conducted an investigation on the death of the patient. He stated, "If the fire had been reported right away the patient could have been saved because he hung from the window for two or three minutes before falling. They could have put up a hook-and-ladder to get him down."

The fire was reported at 6:21 a.m. The engines arrived two to four minutes later because the Battalion is right around the corner.

The staff's course of conduct was negligent in the following manner:

First, the initial fire that the patient set should have been immediately reported. He should have been searched more thoroughly for matches, and the room where he was should have been searched. He should not have been put in Room 153 as it was not designed as a seclusion room. According to 14 N.Y.C.R.R. 23.6, a patient put in seclusion must be visited at least once every hour. The patient should have been checked upon while he was secluded in Room 153. When the aides discovered the fire, one of them should have immediately turned in an alarm. Then the operator should have been called on extension 2333. As previously indicated, having rules and procedures is not enough. They must be followed.

On September 17, 1974, officials at Engine Company 61 wrote a letter to the hospital which suggested that the hospital personnel be reminded to pull the alarm box upon discovering every fire. The letter also recommended that the key-box system be directly connected to the Fire Department.

This letter was prompted by the death of a patient at the hospital. The following is a summary of the incident. The letter stated that the corrections were to be made by the company that installed the system.

On September 23, 1974 a memo was issued to all Chiefs of Service. It put rules into effect regarding the possession of matches by patients. It stated that no patient is allowed to have matches in his possession on the ward. Any patient found with matches is to be restricted in his ward activities. The staff is to light cigarettes for the patients and any patient smoking in seclusion is to be constantly watched.

1. Recommendations Relative to Fire Safety

No deaths or injuries were caused by the lack of an internal bell alarm system for almost two years. The system of calling in fires over the p[illegible] worked well enough to avoid incidents but the system should have been corrected more quickly. Repairs were held up by lack of State funds. They were further delayed because Albany was dedicated conceptually, to an open pull-box system which proved unworkable.

The fire safety at Bronx State would be adequate if the lower staff members followed the rules and reported all fires and keep matches away from the patients. The staff has been commended by the Fire Department for extinguishing small fires they find. However, they should report those fires in addition to putting them out.

It is further recommended that the internal key-box system be directly connected to the Fire Department to save time in the reporting of fires.

Although the Fire Department knew about the unrepaired fire alarm system it was unable to do anything about it. With respect to State facilities, the New York City Fire Department has no enforcement power at all. For example, that State is not required to comply with the New York City Fire Code. The Fire Department's only resource is to make recommendations to the director of the institution, who then transmits them to Albany. The Fire Department also conducts safety inspections at Bronx Psychiatric Center. However, corrections of discovered deficiencies or violations lay behind those which are necessary at the institution. It is thus recommended that the Fire Department be given enforcement power over State institutions so that the safety of patients in those institutions is better protected.

A further problem in reporting fires exists because there are two telephone extensions at the Safety Office. One extension (2222) only rings in the Safety Office and is to be used for general business and emergencies of a non-fire nature. The other extension (2333), the fire phone, rings in the Safety Office and at the telephone operator's station. In that way the safety officers can come right over to the scene of the fire and the operator can pull the alarm which rings in the Fire Department. The operator then calls the Fire Department to give more details about the location of the fire.

Problems with this two number system have resulted from staff members calling 2222 instead of 2333. This wastes time because very often there is no one in the Safety Office to respond. Also, the information about the fire is not immediately received by the operators, so the alarm to the Fire Department may never get pulled.

This is just another example of the subordinate staff not being properly instructed by their supervisors in proper fire and safety procedures. It cannot be stressed enough that it is no use having good procedures if those procedures are not known and used by everyone. It is recommended that the system be changed to prevent future problems of this nature.

PART TWO

VII THE CRIMINAL JUSTICE SYSTEM AS IT PROVIDES FOR THE CARE AND TREATMENT OF THE MENTALLY ILL DEFENDANT. THE SYSTEM ANALYZED, THE SYSTEM'S SHORTCOMINGS AND RECOMMENDATIONS FOR IMPROVEMENT

A. From Arrest Until Arraignment

1. The Role of the Police Officer

Occasionally, a police officer will encounter in the course of his official duties an individual who is severely mentally ill. The officer's subject may be hallucinating, gesticulating or acting in some rather bizarre or seemingly unexplainable manner. In this process of "acting out" the subject may, in fact, be violating sections of the Penal Law. Fortunately, however, the officer frequently senses under the above described circumstances that the subject's aberrant behavior is motivated by unseen and essentially uncontrollable forces. He concludes through observations that neither alcohol nor drugs has caused the subject's behavior and in turn deduces that his actions are the products of mental illness. The officer oftentimes thereupon treats the individual as a person in need of psychiatric care, instead of as a suspect in a criminal case.

In other words, a police officer discovering someone appearing to be mentally ill and engaged in minor criminal activity, has a choice. He may either arrest the individual charging him with the offense which technically may have been committed or, pursuant to appropriate procedures, seek to have his subject hospitalized by bringing him, frequently in handcuffs, to one of the nearby voluntary hospitals having ample psychiatric services, one of the Municipal Hospitals in the Borough with psychiatric facilities [in the Bronx there is Bronx

Municipal Fordham Hospital and Morrisania City Hospital], one of the psychiatric emergency facilities available [in the Bronx there is only one emergency room located in the Bronx Municipal Hospital] or to the nearest State Mental Hospital [in the Bronx, the Bronx Psychiatric Center].

a. Commitment or Treatment

If the police officer decides to treat the person conducting himself in a manner which in a sane person would be disorderly he will usually call for an ambulance (under Police Patrol Guide Procedure No. 106-11). If none is available, he'll take the subject into safekeeping by bringing him back to the station house where the officer will again call for an ambulance. When the emergency vehicle arrives, the officer will ride in the ambulance (or patrol car if no ambulance is available) with the patient to the hospital and safeguard the patient there until that person is examined.

A police officer may decide to bring the subject to the psychiatric emergency room of Bronx Municipal Hospital. This is usually the last contact the officer will have with the subject. Rarely is a patient who has been brought into the hospital in this manner arrested upon discharge. (Of course patients already admitted to the hospital's psychiatric wards may be charged with crimes committed while on the ward or discovered to have been committed sometime before admission, and therefore arrested, under these circumstances, upon discharge).

The psychiatric emergency room consists of a waiting area, a combined nurses' station and clerical office, several small interviewing rooms and a partitioned and curtained medical treatment area. There are no holding beds in this section of the hospital. The only holding beds available are those in the general emergency room.

The psychiatric emergency room is open 24 hours a day and is staffed by three nurses on the day shift, two on the evening and two

on the night shift. Two psychiatrists are assigned there for one month on a staff rotation basis and two other resident psychiatrists (out of a total of 17), permanently assigned elsewhere, cover the psychiatric emergency room on a part-time basis. Social workers are on duty there during the day, but not in the evenings or at night. There is some clerical staff assigned to this service as well.

At times, it should be noted, the hospital's crisis intervention program provides care for the individual brought to the psychiatric emergency room by the police.

The function of the crisis intervention group is to begin brief psychiatric treatment as rapidly as possible. Thus, someone brought in by the police may be seen immediately in the emergency room and then be given an appointment to return the next day to the crisis group. Appointments for the next few days may then be scheduled for the subject and he may be referred to the Department of Welfare or Social Services to solve his or her immediate problems. The object is to attempt to solve the pressing problems and avoid hospitalization.

The crisis group works in conjunction with the emergency room. It physically adjoins the emergency room and three attending psychiatrists work in both areas. Most of the staff of this group is social service personnel—2 supervisors, some case workers and psychiatric rehabilitation workers (trained at the hospital via a special one year course).

b. Arrest

If the officer opts to arrest the mentally ill individual, either the arresting officer or some other police authority or Department of Correction employee will escort the subject by foot or Police Department vehicle to several places: the local precinct in some cases, central booking, the 42nd Precinct holding cells (unless the subject is released on an appearance ticket), the Bronx Criminal Court detention area and the Bronx Criminal Court courtroom.

From the time of his arrest, on through the arraignment stages of the criminal process, the mentally disabled defendant is forced by the nature of his circumstances to come in contact, both verbal and physical, with a variety of Police Department employees, correction officers, other defendants, attorneys for both the prosecution and the defense, and less often, with his well-meaning and not well-meaning complainant's relatives and friends. Unless the ill defendant is fortunate—in that his case is processed quickly—a number of hours and perhaps even an entire day or longer may pass before some sort of psychiatric attention (most likely medication) is made available to him. In other words, there apparently is no provision for psychiatric care during the initial processing stages of an arrest.

c. Recommendations Relative to Initial Stages of Police Contact

1. Standards for Arrest or Commitment

Whether the individual police officer decides to arrest an individual acting in a disorderly manner or otherwise, or seek psychiatric hospitalization for him, is to a large measure dependent upon the officer's subjective evaluation of the situation. His determination, for example, may in part be the result of his conscious or subconscious biases against mental illness as determined to some degree by his level of general education, his police training in recognizing mental illness; his prior experiences with the mentally ill; his general state of mind at the time of the encounter as determined by his personality; his recent experiences in his personal homelife and on patrol may also be influential. The officer's interpretation of the incident involving minor criminal activity is also influenced to some degree by whether or not a male or female defendant is involved and whether there was any personal injury or property damage. If the symptoms of the mental illness are not obvious to a layman, the officer may never know the defendant is mentally disabled.

The police officer's determination either to arrest or seek psychiatric hospitalization should not be an exercise in caprice or whim.

The police officer attempts, one would hope, to act, when indicated by the circumstances, for the benefit of the mentally disabled individual involved.

However, left without adequate training as to the symptoms of mental illness, police officers oftentimes unknowingly jail the individual who may well have been better served under the circumstances presented to the officer by psychiatric hospitalization.

It is recommended, therefore, that all members of the force on patrol duty be trained to recognize the symptoms of mental illness, and to distinguish it from other forms of aberrant behavior such as that caused by drugs or alcohol, and to administer a mental status examination so as to aid them in such recognition (as do City Prison Mental Health workers).

Training of this sort may be accomplished in a relatively short time, especially if form tests are used which merely entail listed questions. A booklet may be compiled which contains acceptable and nonacceptable answers.

Perhaps even more advanced courses concerning psychiatric matters should be offered on an optional bases to those officers seeking more knowledge, with the ultimate goal of preparing the police officer to be a psychiatric para-medic capable of providing medication under a physician's directions or of performing some other type of psychiatric service to a severely (and possibly dangerously) mentally ill subject.

Unfortunately, the psychiatric professional community has heretofore looked upon laymen with some degree of suspicion insofar as their ability to make a psychiatric evaluation or judgment as to mental status. Willingness on the part of the profession to train laymen has thus been lacking. Nonetheless, it is now clear that the police officer may be employed as a valuable frontline adjunct to the psychiatric

community, functioning to screen out those who are mentally ill and who have unfortunately demonstrated the severity of their illness in an overt nonserious criminal manner.

The police officer, properly trained, may then make an intelligent evaluation of whether to employ Patrol Guide Procedure 106-11 or not. To implement this suggestion it is recommended that the following additions to the Patrol Guide Police procedures be made:

PROCEDURE: Upon observing an ~~apparently~~ ~~mentally~~ ~~ill~~ ~~person~~ [individual who at first seems to be mentally ill]* conducting himself in a manner which in a sane person would be disorderly or upon receipt of a written statement by a licensed physician:

1. Take person into custody if not already in safekeeping.
2. **[Conduct a mental status examination in a safe area (such as in the patrol car or back at the station house).]
3. [Upon determining that the individual is apparently mentally ill,] call an ambulance. If none is available [and if still situated on the street], bring person to station house and make second call.

In addition, it is evident, in light of the fact that a mental disease or defect—unfortunately for the subject—may exhibit itself in the form of some relatively minor, albeit criminal activity, that the Patrol Guide provision limiting the application of Procedure 106-11 to disorderly conduct is too restrictive to serve a valid purpose. It is thus recommended that the following addition to the procedure be adopted:

Upon observing an individual who at first seems to be mentally ill, conduct himself in a manner which if a sane person would ~~be disorderly~~ [constitute a criminal offense other than a felony or class "A" misdemeanor] * * *

* Material in brackets is to be added. Language stricken by a line is to be eliminated.

** Sections must be renumbered.

2. Psychiatric Emergency Facilities

A proposal has been submitted to the City for psychiatric holding beds at the Bronx Municipal Hospital, but no action has been taken as yet in this regard. (Holding beds reduce the number of total psychiatric admissions by permitting immediate [24 hour] stabilization and then release for out-patient care). It is thus recommended that holding beds with the appropriate attendant medical and psychiatric facilities be established at the Bronx Municipal Hospital.

2. The Role of the District Attorney—Lack of Treatment in Prison Facilities

The mentally ill individual arrested for an offense and awaiting disposition of his case, should not be subject to confinement without being afforded treatment. In view of the apparent incapacity of the Department of Correction to provide adequate treatment for mentally ill persons committed to the Department's custody pending the disposition of their cases, whenever possible, such persons should be confined in civil mental health institutions or receive care, when appropriate, on an out-patient basis. Where this strategy would be invoked it should be so regardless of the possibility of the defendant's technical competency to stand trial or sanity at the time of the commission of the charged offense.

It is fundamentally unfair to deprive a person, who is otherwise bailable, the freedom he might have had, had he not been suspected of being mentally ill. This is nevertheless precisely what occurs in the case of most alleged misdemeanants who are remanded pursuant to CPL §730.30 for competency examinations. Rarely is an individual permitted by the court to seek an out-patient examination.

Certainly it is in the interest of both the state and the defendant to diagnose incompetency if it exists. However, if a misdemeanant is mentally ill—notwithstanding his competency or incompetency—his

is the controlling interest; to wit, to receive prompt professional attention for his illness. It is here that CPL §730.30 procedures present a substantial problem.

The length of incarceration preceding examination is usually from two to eight weeks. During this period, defendants remain in either a cell or, where thought appropriate, in a "dormitory", and do not receive treatment of any kind other than medication. There is neither group nor individual therapy; nor is there occupational therapy or comprehensive counseling of any sort.

After this considerable period, which cannot be accurately categorized as anything other than warehousing, a large number of these individuals although mentally ill are found competent to face the charges against them. Many misdemeanants found competent are permitted to plead guilty to a relatively minor charge and are sentenced to what is termed a conditional discharge—the "condition" usually being a judicial directive that the defendant seek psychiatric assistance. The case alternatively may be dismissed and a civil order is issued.

Those misdemeanants found to be incompetent have their charges dismissed and are treated as civil patients under an order which permits their confinement in a mental hospital for up to 90 days. Some misdemeanants who are competent but nevertheless mentally ill, are tried and convicted or plead guilty and are sentenced to a jail term. Consequently, although mentally ill, misdemeanants are confined in a penal facility where it is unlikely that they will be provided adequate treatment either as a matter of Department of Correction policy or as a matter of right.

It is clear, therefore, that at least in the case of alleged misdemeanants, the state's *parens patriae* responsibility and the interests of a defendant who is mentally ill, combine to override the state's interest in confining a defendant simply so that he will be available

to face the charges against him. Such defendants should be afforded care and treatment in a hospital setting.

In the case of accused felons who may be mentally ill, the state's interest in adequately securing these individuals so as to guarantee their availability to face the charges against them, and the state's duty to see that incompetent defendants charged with crimes are not tried, compels felons' incarceration in prison facilities for examination and treatment.

a. Recommendations for Immediate Commencement of Psychiatric Care for Misdemeanants

To cut short the time during which a mentally ill misdemeanant must be subjected to the trauma of prison life, it is recommended that the following procedure be employed:

1. The police officer in all arrests for an offense must complete a preliminary mental status sheet (similar to mental health referral sheet). If there is suspected mental illness he must complete a mental status examination report. (Short police questions and subject answer form).
2. Both the preliminary report and mental status examination report are completed in quadruplicate:
   a. One copy to the court,
   b. One copy to the D.A.,
   c. One copy to defense counsel,
   d. One copy to R.O.R. probation.
3. A psychiatrist stationed at the central booking area will receive the officer's mental status examination report and review the arrest papers to spot aberrant behavior patterns, and if believed necessary will briefly interview the suspect. The psychiatrist will then complete a short psychiatric report indicating whether the subject is apparently in need of emergency psychiatric commitment, involuntary commitment, or out-patient care (as defined by the Mental Hygiene Law). This report will also be made in quadruplicate and be sent to the same parties named in "2" above.
4. Mental status examination report showing suspected mental illness and the psychiatrist's report attached to the D.A.'s file will alert the assistant district attorney in the pre-arraignment room to scrutinize the merits of the case closely.
   a. If it's a misdemeanor charge or,
   b. If it's a case which may reasonably be reduced to a misdemeanor, and is so reduced in the pre-arraignment room, the assistant district attorney will note on his folder POSSIBLE PSYCHIATRIC DISPOSITION AT ARRAIGNMENT.
5. The assistant district attorney in the arraignment part and the arraignment judge will then be alerted to the situation.
6. If possible, defendant will be brought before the bench immediately.
7. If the assistant district attorney in the arraignment courtroom believes the defendant is parolable and the court is otherwise disposed to parole the defendant into custody of awaiting friends or relatives (if of course the defendant does not appear to be a danger to himself or others as defined by the Mental Hygiene Law section 31.41), or, if the judge, based on the evidence before him believes the procedures of Mental Hygiene Law section 31.43 (subd. b) [providing for emergency observation, care and treatment] are applicable or believes from the evidence presented that the defendant may otherwise be in need of emergency or involuntary care and treatment as provided by Article 31 of the Mental Hygiene Law, the assistant prosecutor may consider the following recommendation for disposition:

a. The defendant will be paroled into the custody of the arresting officer who will then transport the defendant or see to it that the defendant is transported by Police Department or Correction vehicles to a hospital having psychiatric in-patient services.

   1. As an alternative, perhaps the individual may receive an immediate comprehensive examination at the court clinic to see if he's in need of in-patient care and treatment and then, if in need of hospitalization, be sent by ambulance to the hospital. This procedure would be inoperative on night and during weekends when the clinic is closed. The police officer or his designee in the department would have to transfer the subject during these hours. [It is simply noted here that the power and duty to transport and care for the individual in need of emergency care and treatment is already imposed by Mental Hygiene Law sections 31.41, 31.42 and 31.45].

b. The defendant will then be examined by psychiatrists to determine if he is in need of emergency involuntary commitment, involuntary commitment or out-patient care and treatment. If so, the psychiatrist will proceed according to the Mental Hygiene Law to procure his commitment or arrange for out-patient services. If not commitable the defendant is thereupon placed on parole in his own recognizance to return to court on the appointed return date.

c. In either case the police officer need not remain in the hospital after leaving the defendant in the custody of the security officers of the hospital; but it would be good practice for him to remain until the exam is completed.

d. If the individual is committed or enrolled in an out-patient program, or refused commitment or enrollment, a psychiatrist at the hospital will send a report to that effect to the district attorney within 7 days.

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d. If the individual is committed or enrolled in an out-patient program, or refused commitment or enrollment, a psychiatrist at the hospital will send a report to that effect to the district attorney within 7 days.

e. The adjourned date for the case will be at least one month from the date of arraignment.

f. If on the return date, the defendant, having been committed, is still hospitalized continually for one month or has been receiving out-patient care on a regular basis for one month (determined by a phone call) the People will agree to adjourn the case in contemplation of dismissal.

g. If the defendant was hospitalized and released before the adjourned date but is receiving out-patient care on a regular basis the People will agree to adjourn the case in contemplation of dismissal.

h. If the defendant was hospitalized and released or was enrolled in an out-patient program and is no longer receiving psychiatric care of any kind on a regular basis, the assistant will use his discretion on the return date to recommend an appropriate disposition or refer the case for trial.

i. If the defendant was never hospitalized or enrolled in an out-patient program, the assistant will use his discretion on the return date to recommend an appropriate disposition of the case or refer the case for trial.

j. If the defendant had been hospitalized, escaped, but had returned on or before the adjourned date as determined by telephone call, the People will *consider* adjourning the case in contemplation of dismissal upon the physician's statement on the return date that the defendant is then hospitalized.

k. If the defendant had been hospitalized (as determined by telephone call), escaped but appears in court on the adjourned date, the People will consider an appropriate disposition or refer the case for trial.

l. If the defendant had been hospitalized, escaped and does not appear in court on the return date, a bench warrant will be issued (as it will when the defendant was not hospitalized and does not return to court).

m. If the defendant had been enrolled in an out-patient program, failed to attend during the month and returns to the program just before the return date the People will consider an appropriate disposition or refer the case for trial.

B. From Arraignment Through Disposition

1. The Bronx House of Detention for Men

Defendants who have been arraigned and who have not been paroled or who have not made bail in the Criminal Courthouse will be transported by the Police Department vehicles and be housed in the Bronx House of Detention for Men until the disposition of their case.

For purposes of this analysis all defendants entering or returning to the Bronx House of Detention from either the Criminal or Supreme Courts of this state may be divided into those defendants committed pursuant to Article 730 orders of examination and those who are not.

a. Screening and Treatment of Defendants Committed Pursuant to an Article 730 Order of Examination

The defendant entering the Bronx House (and this is true with all new admissions) is first fingerprinted and searched. His valuables are then inventoried and he is given a shower. He is then physically examined by a medical doctor. (One is on duty seven days a week, twenty-four hours a day). As part of the medical examination, the physician completes a mental status referral sheet which notes the presence of symptoms of mental illness.

Since most inmates arrive at the detention center in the evening, the mental health staff does not receive the referral sheet until the following morning. If the admission is in the morning or afternoon the staff will receive the sheet forthwith. In either case they will receive a referral only if there is a positive indication of symptoms of mental illness.

Mental Health Staff

The mental health staff consists of the following: there are nine part-time psychiatrists providing a total of 77 hours of psychiatric services per week. There are two vacancies and there is no full-time psychiatrist on staff.

Approximately 20 nurses administer medication and at least 2 nurses are on duty at any one particular time. One neurologist attends on Fridays. One psychologist is there one day a week. In addition, there are six mental health workers, one of which is a supervising mental health worker.

Formal training for mental health workers consists of a one to two week program conducted by one of the members of the Department of Prison Mental Health Services. The remainder of training for mental health workers is on the job. Mental health worker trainees work with another mental health worker as a team for a period of time, before taking on their own duties. All mental health workers are required to take a civil service examination, and all mental health worker trainees are required to have 6 months' experience on the job. Mental health workers need one year's experience. A senior mental health worker need have an Associate of Arts degree nad one year's experience. If the person has less than 2 years of education he is required to have that much more on the job experience commensurate with the deficit in his education to qualify for the position.

The supervising mental health worker must take a civil service exam which consists of both written and oral segments. The oral part

is conducted by psychologists and psychiatrists. To qualify, the supervisor is required to have a Bachelor's Degree and one year's experience. For every year less of education he need have another year's experience.

Psychiatric Interview

The mental health worker interviews the defendant—who has been housed on either 2 South, the psychiatric observation cell block, or 6 West, the psychiatric dormitory, in either the 2 South correction guard's room, or if the defendant is extremely agitated, in the defendant's cell on 2 South. Those housed on the dorm are interviewed in a former barber shop room.

Those individuals who are not considered by the mental health staff to be dangerous to themselves or others and are believed to be able to function in a controlled environment, will thereafter be housed in the dormitory, 6 West. Suicidal patients may also be kept on 6 West where they may be constantly observed. (Those both agitated and suicidal will be kept on the 2 South cell block).

The mental health worker, as part of his interview, administers a mental status examination (merely questions designed to determine the subject's ideation, judgment, level of hostility, scapegoating and general sensorium, *i.e.*, awareness of time, date and place).

A mental health folder is then compiled, containing the mental health worker's report, and the defendant's psychiatric history, which is obtained in the following manner:

1. The workers first check their own files to determine whether the individual had ever been in the House of Detention before and had been referred to the mental health staff. Both a current and past card file is maintained.
2. The defendant's parents and friends, if available, are then questioned about any prior psychiatric hospitalization of the defendant.

3. The defendant himself is questioned as to whether he had been hospitalized for a mental or "nervous" condition (*i.e.*, psychiatric hospitalization) and if so, where.
4. Workers will then attempt to obtain information from any hospitals at which the defendant may have been an in-patient or out-patient.

The mental health staff later conferences the case and decides whether the subject is in need of psychiatric care. If so, and most individuals committed for an Article 730 examination do require psychiatric aid, the subject is assigned to the next available psychiatrist.

Meanwhile, extremely assaultive patients are housed on 2 South and in some cases put on "lock-in, feed-in" status. Suicidal patients are surveilled by the detention center's suicide watch, a team of inmates trained by the mental health staff to prevent the occurrence of suicides.

The psychiatrist to whom a defendant has been assigned subsequently examines the subject, prescribes appropriate medication and issues his own report or summary on the subject's mental status. The House of Detention psychiatrist prescribes phenothiazines (anti-psychotic drugs), prolixin, minor tranquilizers (such as valium) and anti-depressants, through either pills, liquid or intra-muscular or intravenous injection. The prescription for minor tranquilizers must be renewed every week. Anti-depressants are renewed after two weeks. Anti-psychotic drugs are prescribed for three-week periods. Forced medication is not permitted unless the subject is in the act of harming himself or another.

1. The Competency Exam

Upon admission pursuant to an order of examination the defendant is immediately scheduled by correction authorities for the competency examination at either the Bronx Court Psychiatric Clinic or

the Bellevue Psychiatric Prison Ward. The vast majority of the exams are done at the court clinic. The earliest appointment at the clinic is usually between one to two weeks away. Those defendants who are extremely agitated or suicidal may be seen at the clinic, upon special request, on an earlier date.

(a) Emergency or Management Cases

Defendants who need be examined for competency to stand trial but who are also in immediate danger of harming themselves or others will be scheduled for examination at Bellevue.

Defendants originally scheduled for a court clinic examination may, if they become an emergency case (homicidal or suicidal activity), also be transferred to Bellevue Psychiatric Prison ward for emergency treatment.

The mental health staff initiates this transfer through the central office of the Department of Correction.

Many defendants admitted to Bellevue as an emergency transfer, or indeed even as a management problem transfer, who had been ordered examined under Article 730 of the CPL will remain at the prison ward and be examined there. Others are returned to the House of Detention after a matter of hours or days, following initial stabilization through medication. Some defendants are returned immediately, having been diagnosed by Bellevue physicians as non-dangerous.

As an alternative to transferring to Bellevue an individual awaiting a competency examination who becomes a management problem or psychiatric emergency case, the House mental health staff may seek to transfer the defendant to Rikers Island Hospital. At this institution the defendant may be force-medicated. There is, however, an advantage to sending the defendant to Bellevue instead of to Rikers Island

Hospital. Bellevue is equipped to administer the psychiatric competency examination and thus may hasten the return date while providing continuous medication at the same time.

When mentally disabled defendants are returned from Bellevue Prison Ward or Rikers Island Hospital following stabilization by medication or otherwise, the House of Detention receives from the former institution a clinical summary and a cover letter of a paragraph or two describing the defendant's mental condition and the medication which he has been receiving.

(b) Exams at the Clinic

Defendants examined at the Bronx Court Clinic may have to return a second time to be examined by another psychiatrist (Article 730 requires examination and report by two psychiatrists). The total time from admission to the detention center until return to court on order of examination may be six to eight weeks (when the court-ordered return date is 30 days). The return date may have to be extended 30 days purusant to the Criminal Procedure Law.

b. Defendants Who Have Not Been Committed Pursuant to an Article 730 Order of Examination

Of the approximately 450 to 460 inmates of the Bronx House of Detention close to one-half come in contact with the mental health staff at one time or another.

Any inmate suffering from some form of mental illness might undergo the same initial steps that one committed pursuant to Article 730 might experience. However, if the physician performing the medical examination, upon admission, fails to spot and indicate some aberrant behavior of the defendant on the mental health referral sheet, the mental health worker will neither conduct an interview nor in turn refer the case to a psychiatrist.

However, absent referrals to the mental health staff by the medical doctor, correction guards, other defendants or the subject himself may alert the mental health workers to the subject's mental illness.

1. Emergency and Management Cases

Emergency patients are treated in the same manner as those under an order of examination. Bellevue Psychiatric Prison Ward, however, usually just stabilizes emergency and management cases and returns them to the House of Detention within a matter of hours or days. Often the defendant is returned immediately, having been diagnosed by the Bellevue psychiatrists as not being in a state of immediate danger to himself or others. He may also be returned because he arrived at the ward after 4:00 p.m., the time up to which the ward accepts management problem admissions.

An individual in a severely agitated state sent to Bellevue for stabilization may become the subject of a 730 examination on motion of the warden of the prison ward.

c. Disposition of Defendants Under Mental Health Care

Each time an individual is sent to another penal institution for any purpose (whether for 730 examination or not) a photostatic copy of his entire mental health file accompanies him. The destination of a person who is sent to Bellevue and is examined there, found incompetent and transferred to a state mental institution, is unknown to authorities at the House of Detention. However, when an individual's case will be disposed of in court, or when the man will be released on parole, the House of Detention mental health worker will notify the aftercare personnel. (See pp. 117-119 for discussion of Prison Mental Health Aftercare).

d. Arrivals from State Mental Institutions

Some patient-defendants on 2 South and 6 West are transferees from state mental hospitals such as Mid-Hudson Psychiatric Center and Bronx Psychiatric Center who have been found competent to stand trial.

On the day the individual is to be transferred, the House of Detention is notified by telephone from the Prison Mental Health Central Office of the defendant's mental condition and medication.

When the returnee arrives from the state mental institution he is housed in the mental observation unit (2 South). A day or so following arrival of the returnee, the mental health staff will receive a clinical summary from the tranferor institution. Bronx Psychiatric Center, however, does not send a clinical summary to the House mental health staff.

e. Recommendations Relative to the Bronx House of Detention

1. Initial Screening at the Bronx House

Since the initial medical referral form is filled out by a medical doctor and not by a psychologist or psychiatrist, the chances are, in some cases, that someone, who at the time of admission has not been ordered examined by the court but who is nonetheless suffering from a non-acute mental illness or some illness in partial remission, may be diagnostically overlooked.

It is thus recommended, as a supplement to the p[illegible]dical referral form, that questionnaires be employed (as in the [illegible]cent Remand Shelter) to help the mental health staff in the initial screening of all new admissions to the institution. These questionnaires may also be used by the professionals of the mental health staff when prescribing in-house treatment and aftercare programs.

To aid the mental health staff in primary diagnosis and treatment they should also have completed access to the Department of Mental Hygiene's central computer bank of information on prior state mental hospitalizations. In this manner, pertinent state hospital records may be immediately obtained and used for diagnosis and treatment purposes.

As an additional aid to preliminary treatment, Bronx Psychiatric Center should be instructed to send a copy of their clinical summary to the Detention Center (as does Mid-Hudson Psychiatric Center) on all returns of defendants found competent to stand trial. Copies of all clinical and diagnostic data compiled while at the state institution should also be sent to the detention center so as to provide the prison mental health staff with as much psychiatric information as possible.

2. *Treatment*

Psychiatric treatment is virtually non-existent in the Bronx House of Detention. (The function of the mental health staff is to help maintain custody, see that the individual defendants receive appropriate medication, if desired, and to act in emergencies to stabilize the subject).

Some of the reasons why treatment is non-existent are set forth below.

Although there is a screened in room on 2 South which may be and indeed was at one time used for group and individual therapy it now remains practically unused. The inmates receive sporadically art therapy in this area. The explanation for this non-use is that the cell block adjoining the screened area has a gate which must be kept open so that the floor guard can maintain some type of control over the block and the screened in area—the entrance to which is in the block area—at the same time. This creates a security problem and therefore the screened room is not used. At one time therapy sessions

were run on 2 South by a full-time psychologist. But his position, on last inquiry, had been cut from the institution's budget following his departure from employment by the Department of Prison Mental Health Services. Also, psychiatrists, given the limited time they have, do not have the opportunity to conduct treatment sessions for all patients. The one type of therapy actually available is chemotherapy (treatment with drugs) and in addition some counseling on a minor level. Yet, patients have been asking for someone to speak with, not drugs. In addition, there is only one Spanish-speaking mental health worker and one part-time psychiatrist who speaks the language. Verbal communication with the largely hispanic population of 2 South and 6 West is thus not what it should be.

These are but some of the minor specific factors which contribute to an overall non-therapeutic environment at the Bronx House of Detention. The fundamental reason for lack of treatment, however, is the absence of adequate professional staff (as hinted at previously). Without an appropriate number of psychiatrists and psychologists available, psychiatric services cannot be delivered to the inmate population. (Money for an increase in staff does not seem to be forthcoming from the City).

Recently, the lack of treatment has become a more crucial issue at the House of Detention for basically two reasons:

First, more and more overtly psychotic individuals are being returned from state mental institutions (such as Mid-Hudson and Bronx Psychiatric Center) who are competent to stand trial, but who are overtly psychotic. The Detention Center authorities indicate that such an occurrence would be relatively rare in the past (one such individual per month). This phenomenon we note is probably a ramification of the Matteawan bill [see pp. 145 *et seq.*]. Defendants being transferred from Mid-Hudson to Bronx Psychiatric Center apparently cause a premature "spill-over" of one-time incompetent defendants back into the criminal justice system).

Unequipped to deal with overtly psychotic inmates the mental health staff is taxed to its limits. Individual inmates acting out, who refuse medication or are non-responsive to medication, take up a great deal of the mental health worker's time and energy. Inmates are continually being transferred out to Bellevue or Rikers Island Hospital. In the alternative, they are locked in and fed in the cells. Some are suicidal and some assault the prison guards and mental health personnel. Oftentimes acutely ill defendants are immediately returned from Bellevue or Rikers Island Hospitals in the same mental state they were in when they were transferred out. The reason is that the Bellevue or Rikers Island Hospital psychiatrists disagree, in approximately 90% of the transfer cases, with the diagnosis which had been reached by the House of Detention psychiatrist—the diagnosis which had been the basis for the transfer.

Second, in addition to the fact that the mental health staff is pressed to its limits, it is evident that because of several factors the House of Detention must house the mentally ill defendant for longer periods of time than they do the non-mentally ill defendants. Thus, not only is the staff non-equipped to deal with the acutely psychotic patients (whether transferred from state mental institution or not) but they have been forced to function at this level of unpreparedness for great lengths of time as well.

The causes for the extended stay of the mentally ill inmate are as follows:

First, approximately 50% of the entire detention population, whether mentally ill or not, remains in the House of Detention, on the average for more than 30 days.

Second, mentally ill individuals scheduled to be examined for competency to stand trial, sometimes must remain in the House six to eight weeks awaiting completion of the examination and preparation

of the report (see p. 116). Hearings on the reports are sometimes adjourned, adding additional delay.

Third, individuals sent to Rikers Island Hospital or Bellevue Prison Ward as management problems or emergencies are often returned within a matter of days only to remain in the House until some disposition of their case. Some have to wait (in the first instance) for an available bed there. (Bellevue accepts only 5 persons from the entire city per day; Rikers Island accepts 20 persons from the House of Detention during the entire year).

Fourth, inmates suffering from some mental or other medical problem cannot—according to Department of Correction policy—be transferred to another detention center or city prison facility. Many inmates who are admitted and do not have mental problems are readily transferred to Sing Sing upstate so as to prevent overcrowding of the detention facilities. Mentally ill defendants, however, must remain in the House.

Fifth, trial calendar delays prolong stays in the institution. Without appropriate psychiatric help many inmates return to the streets in the same, if not worse mental condition they were in when arrested.

By providing treatment to inmates awaiting trial, valuable time during which psychiatric progress may be made will no longer be lost forever. Inmates awaiting competency examination may attain competency at an earlier time than they might have had they not received treatment; and most important, perchance treatment at this initial stage of detention will to some extent reduce the number of individuals involved with the criminal justice system who eventually, in civil life, require intensive in-patient care and treatment in a mental hospital.

It is accordingly recommended that comprehensive psychiatrically acceptable treatment programs be developed for each inmate professionally judged to be mentally ill and carried out by professionals and mental health workers on a cooperative basis. Treatment programs

should include, but not be limited to, individual and group psychotherapy, occupational therapy, dance and music therapy. The aim should be to institute treatment as soon as it is reasonably feasible to do so following admission to the institution.

3. Facilities

To implement and maintain programs of treatment, adequate physical quarters must be maintained for mental health records, interviewing inmates, staff and clerical equipment. An examination of the facilities of the Bronx House of Detention showed that office space for the mental health personnel is lacking. (There were 3 desks in a small room and one file cabinet had to be kept in a closet; the officer's room on 2 South and a barber shop room on 6 West doubled as interviewing rooms).

It is recommended, therefore, that a re-evaluation of the available space at the Bronx House of Detention be carried out immediately, with a view toward making additional facilities available to the mental health staff.

4. Mental Health Staff

The major functions of the mental health staff are: (1) to screen patients referred by the medical doctor, inmate population, uniformed guards and the subject himself; (2) to perform crisis intervention services; (3) to counsel inmates on daily rounds; (4) to deal with aftercare referrals; and (5) to process and screen admissions and returnees to the House of Detention from outside institutions such as Bellevue Psychiatric Prison Ward, Rikers Island Hospital, Mid-Hudson Psychiatric Center and other city correctional facilities.

Specifically, the mental health staff of the Bronx House of Detention is involved with 6 areas of inmate population:

1. 1 North which houses the homosexuals, those under protective custody and the overflow from 2 South.

2. 2 South and the remainder of 2nd floor which houses overt psychotics, assaultive inmates, lock-in, feed-in status inmates, House gang and sentenced inmates and general population on 2 North.
3. 4th and 5th floors—housing 6 West overflow, addicts, three dorms and six cellblocks of general population.
4. 6th floor—6 West dorm and 6 South (Bing) houses inmates in remission, personality disorders, returnees from state hospitals who do not need to be locked-in, some in need of protective custody, administrative segregation.
5. The receiving room which holds extremely agitated patients or those subject to becoming a scapegoat of the other inmates.
6. Those inmates who are to be placed in aftercare.

The mental health workers have contact with a total of some 60% of the entire inmate population of approximately 450. That computes to be one mental health worker for every 35 inmates under "treatment."

At present, the staffing pattern for mental health workers does not allow for groups, one-to-one therapy sessions, intervention with the court or outside agencies and does not provide for any back-up personnel for special situations such as absence or holidays.

Psychiatrists

Although the figures provided by the Department of Prison Mental Health and the Mental Health staff of the House of Detention as to the number of hours of part-time psychiatric services differ (76 hours according to the former, 49 according to the latter), the number of hours in either case does not provide for any individual or group sessions by psychiatrists or for any back-up psychiatric personnel.

The plight of the mentally ill defendant is one which demands immediate attention by public officials. As more and more severely psychotic inmates are being returned from the state mental hospital system as competent to stand trial, the problem, at least at the detention center, becomes more and more apparent. As inmates are eventually released to the streets on parole or following the service of their sentence, the problem will become more and more visible to the public.

To stop the release of essentially untreated mental patients, some potentially dangerous to themselves and others, all efforts should be made to provide inmates with treatment while still in the Bronx Detention Center.

It is recommended that the mental health and prison guard staffing pattern of the Bronx House of Detention (including psychologists, mental health workers, clerks, typists, etc.) be re-evaluated and upgraded in terms of number and hours of service so as to provide adequate personnel for the institution and maintenance of appropriate comprehensive treatment programs; staff sufficient in number to provide all those inmates of the facility, professionally judged to be mentally ill, with adequate, in terms of quantity and quality, and appropriate psychiatric services. (Services such that an inmate accepting them would, if possible, be restored to a state mental well being).

2. The Bronx Court Clinics

a. Function

The Bronx Criminal and Supreme Court Clinics were established to perform psychiatric evaluation in criminal proceedings for the court, the Department of Probation, defense counsel and the District Attorney. Specifically, the clinic's psychiatrists examine defendants to determine their competency to stand trial and for sentence and parole evaluation purposes.

b. Location

The Criminal Court Clinic is located in the Criminal Courthouse, and the Supreme Court Clinic in the Bronx County Courthouse. Both clinics are centrally situated between the correctional complex on Rikers Island and the Bronx House of Detention in the Bronx, the two institutions which provide the bulk of the psychiatric referrals.

The clinics were located in the respective court buildings in an attempt to enhance communication in psychiatric matters between the clinics' psychiatrists and the judges, the assistant district attorneys, legal aid, the court clerk and the probation office. For instance, at times, brief informal hearings are held in judges' chambers concerning the mental status of a defendant. On these occasions, the psychiatrist involved, being located in the courthouse, may be called away from the clinic for a few moments to attend the hearing or conference, review the patient's charts, and discuss the pros and cons of the psychiatric report which he had issued. There are times, also, when the supervisor of the clinic will spend part of his day in the probation office reviewing various cases for that department. The clinic being situated in the building which houses the office of the Department of Probation, facilitates this review service. And the clinics are situated in the court because, in some cases, it is believed, a defendant who is extremely agitated in the courtroom may benefit from the immediate examination and treatment he is able to receive at the courthouse directly following his court appearance.

c. Services

Both the Criminal and Supreme Court Clinics together employ 2 full time psychiatrists and 2 part-time psychiatrists (2 days a week). (They are presently training a third psychiatrist). All social work and psychological work-ups are done by a psychologist.

The clinic's psychiatrists interview between 50 to 60 defendants a month, approximately 600 per year.

d. Procedure: Competency Exam

The procedure for competency examination is essentially the same as that employed for examinations for other purposes such as parole or sentencing, unless the individual is on parole.

The correctional facility receiving an individual ordered to be examined calls the clinic and schedules an appointment for the examination. Appointments are scheduled between seven to fourteen days from the date of the call.

If the subject has already been scheduled for a competency examination and prior to the scheduled date becomes a severe management problem to the correctional facility in which he is being held, the mental health staff of that facility will request that the date be moved ahead. In this manner, all criminal court defendants will be returned to court for a hearing and disposition earlier than they might have been otherwise (see p. 103).

If the subject has been scheduled for a competency examination and prior to the appointed date becomes suicidal or homicidally aggressive, he may be sent by the correctional facility to the Bellevue Prison Ward. In this event: (a) the correctional facility's mental health staff is required to call the clinic and inform them they have sent the subject, who had been scheduled for examination at the clinic to Bellevue Prison Ward; (b) the Department of Correction is required to call the clinic to inform it of the transfer; and (c) Bellevue Psychiatric Prison Ward is also required to call the clinic and inform its personnel that they have received the 730 examination patient and will do the examination there. (Any information which the clinic may have collected concerning the defendant's mental status is then passed on to Bellevue personnel via the telephone).

Once the defendant has been examined by one psychiatrist at the clinic he may have to return again to be examined by a second psychiatrist (unless both exams are done on the same day, which is rarely if ever done).

After the defendant has been examined by two psychiatrists and returned from the clinic to the correctional facility by Department of Correction vehicles, the clinic can have the reports prepared within five days. In Criminal Court cases, the clinic, by arrangement with the head clerk of that court, controls the return date for the competency hearing. On the order of examination, the clinic's personnel checks boxes indicating whether the subject is competent or not, whether he requires medical or psychiatric treatment and indicating the date on which the report will be ready for court purposes. The hearing is usually held on this date. (The return date in most cases is 12 or 13 days from the date of the order of examination, even though the law permits 30 days and an additional 30 days in extenuating circumstances for completion of the exam).

e. Recommendations Relative to Delay Between the Examination and the Court Hearing

Due to adjournments, the hearing on a competency report (see p. 116) is delayed sometimes a matter of weeks. At times there is a substantial delay between the exam by the first and by the second psychiatrist. During these intervals of time, the subject's mental status may, and indeed does in a number of cases, change significantly. An individual found incompetent by the clinic psychiatrist may be, psychiatrically, an essentially different individual by the time he gets to court.

It is thus recommended that a system for the advancing of psychiatric cases on the Supreme Court calendar be devised so that a competency hearing may be held as soon as the reports have been prepared.

A possible method might be the following:

1. When the clinic has competed its examination it issues an "advance notice" to the clerk of the part in which the case had been calendared.
2. The clerk of the part in turn will notify the assistant district attorney and defense counsel of the advanced date he has chosen.
3. The district attorney as well as defense counsel will then be able to call the clinic and obtain as much information as they can before the return date.

In this manner, even if the defendant's attorney or the assistant prosecutor wishes to controvert the psychiatric report and therefore must ask for a short adjournment to prepare, the case will have been advanced a number of days and the defendant will be that much closer in time to receiving appropriate care and treatment.

In addition (and the following discussion and suggestions pertain to the Bellevue Prison Ward hearings as well), it has become evident that court delays in psychiatric competency cases have been brought about in part by a lack of preparation, sometimes by the People but most times by the defense, and by the inability of both sides to agree upon a mutually convenient date—if an independent psychiatrist is called for—on which their respective psychiatrist can appear in court.

It is recommended therefore that after an established period of time (for example three days following receipt of all necessary and appropriate psychiatric reports the necessity and propriety determined by the court) adjournments will be had only upon an order to show cause, supported by an affirmation setting forth the facts which necessitated the request for an adjournment. If after receiving the initial psychiatric reports the People or defense counsel asks to retain an independent psychiatrist, the following procedure is recommended:

1. The prosecutor or defense counsel be required to obtain the name of a psychiatrist willing to perform the examination. Such name need be obtained on or before the fifth calendar day (not including Saturday, Sunday or legal holidays) following the date on which the request for an independent psychiatrist is made. [Indigents may now apply to a special council established in the First Judicial Department]
2. Immediately upon obtaining such name the prosecutor or defense counsel will be required to relay the information to the bench, at which time the court will issue a written order to the effect that the examination shall be completed and a report prepared on or before the fifth calendar day (excluding Saturday, Sunday and legal holidays) following the date of the court's order.
   a. Defense counsel or the prosecutor is directed to subpoena the chosen psychiatrist for the specified return date.

To eliminate delay between the examination by the first and second psychiatrists at the clinic it is recommended that both exams be scheduled for the same day in all cases possible. If not possible with existing staff, it is recommended that additional psychiatrists be employed.

3. Bellevue Psychiatric Prison Ward

a. Functions

The Bellevue Hospital Psychiatric Prison Ward has essentially two functions. First, its psychiatrists administer court-ordered examinations to determine the competency of criminal defendants to stand trial. Second, the ward's psychiatrists prescribe and administer

emergency psychiatric services to inmates of the New York City prison and detention facilities.

The ward has a listed capacity of 54 beds.

b. Admission Procedures

1. Emergency Cases and Management Problems

Only those individuals who may be classified as homicidally aggressive or suicidal are admitted to the ward for emergency treatment 24 hours a day. Emergency cases rarely stay longer than a matter of hours or days.

Individuals who are management problems in the prisons are admitted to the ward on a limited basis. (Five individuals, per day, from the entire city are allowed admission to the ward).

In the event either category of inmate is to be transferred from the Bronx House of Detention to Bellevue, the detention facility authorities (Deputy Warden or mental health staff) will contact the prison ward (either directly at night or through Correction's central office during the day) to determine if there is an empty bed available.

The physician on duty at the ward then either approves the transfer himself or seeks the approval of the unit chief, if he's available at the time. The approval is subsequently noted on the inmate's transfer papers.

The correction facility, through the Department of Correction's central office initiates the transfer. The transfer is accomplished by Department of Correction vehicles.

An individual who arrives at the ward after 4:00 p.m., who is not classified as an emergency case by the psychiatrist on duty at the

ward when the subject arrives (and the psychiatrists on duty may be someone other than the psychiatrist who approved the transfer in the first place), will be returned to the prison of origin, immediately. Admissions of management problems end at 4:00 p.m.

2. Competency Examination Admissions

Most of the competency examinations in Bronx cases are performed at the court clinics (see pp. 100-105). However, an individual ordered examined may be considered dangerous to himself and others and thus may be scheduled by correction authorities (often at the request of the Bronx House or Rikers Island mental health authorities) for examination and medication in the more controlled environment of a psychiatric prison ward. The number of patients falling within this category who may be admitted to the ward is again limited to a total of five a day to prevent overcrowding of the facility. (Competency examinations for Queens, Kings and Richmond County cases are conducted at the Kings County Psychiatric Prison Ward).

Judges sometimes order that a particular individual be examined for competency (or in fact for sentence evaluation or parole purposes) at the Bellevue Prison Ward. The hospital, having control over its admissions has the power to refuse to accept such a patient. Out of respect for the Bench, however, they rarely do.

Patients who have been ordered examined and have been transferred from a correctional facility, pursuant to the notification procedure set forth under emergency admissions, but who arrive after 4:00 p.m., may nevertheless be refused admission by the hospital's staff.

At times, a patient who has already been scheduled at the psychiatric court clinic for an examination to determine competency will, before the scheduled date, become a severe management problem to the facility in which he is housed. In this circumstance, the facility

will transfer the person to Bellevue. After the individual has arrived at the prison ward, and been stabilized on medication, the staff of the ward may perform the competency examination as well, and thereafter permit the patient to be housed on the ward until there is either a disposition back to the prison facility (if competent) or to a state mental hospital (if incompetent).

c. *Treatment*

Upon arrival at the prison ward, patients are screened by the ward resident and medication is prescribed and treatment by the staff is commenced. The ward is covered by 5 psychiatrists. Since their time in the hospital is spent in part on other wards, they provide the equivalent of the services of 4 full time psychiatrists. Hospital residents in psychiatry are assigned to the ward during evenings and weekends. There is also an attending physician on duty during the day. In addition to psychiatrists, there are 3 full time social workers, 1 ward supervisor, 41 full time nurses (RN's, practical, aides), 2 full time activity therapists, 1 part-time activity therapist, 1 music therapist, 1 administrative assistant and 4 secretaries. Every available form of medication is utilized.

Treatment teams (consisting of psychiatrists and other professional and para-professionals), delivering whatever psychiatric services they can, meet every morning to conference cases. On occasion consultants from the psychiatric staff of the hospital are called in to conference a case.

The administrative clerk of the unit attempts to gather as much information as he can concerning the subject's psychiatric history, including prior state hospitalizations; data which he obtains by making a phone call to the centralized computer facilities of the Department of Mental Hygiene of the State of New York. The psychiatrists and the clerk attempt to speak with the subject's family and friends to cull from them any other information they can concerning the subject's mental status.

d. *Disposition of Patients Sent to the Ward*

The average stay of patients admitted on an emergency basis is 9 to 11 days.

Patients in the ward for competency examination purposes will remain there longer than emergencies due to the time which must be spent administering and evaluating the examination, awaiting a court hearing, and arranging for transfer either to a state mental hospital if found incompetent, or to the prison of origin if found competent.

Whenever the inmate is sent from Bellevue, be it to the correctional facility from where he came or to the state mental hospital designated by the Commissioner of the Department of Mental Hygiene, the Bellevue staff prepares a clinical summary and sends a copy of it to the institution to which the patient is transferred.

e. *Recommendations*

1. *Bellevue, Lack of Bed Space*

Due to bed space limitations at the Bellevue Prison Ward, defendants sent there from the various city correctional facilities for emergency purposes must be sent back to the prisons within a short time so as to make room for new emergency admissions. Since the stay of most of the defendants is relatively short, the professional staff is rarely, if ever, able to institute and maintain comprehensive programs of treatment. The long range solution is expansion of the psychiatric prison ward facility to provide adequate bed space for all the city and detentioon cases in the Bronx and Manhattan which require psychiatric hospitalization. The state, however, has been reluctant to provide monies for the appropriate expansion of psychiatric service. It is, nonetheless, recommended that the city's proposal for increased bed space be adopted by the State Department of Mental Hygiene. In this manner the number of prison ward beds will be sig-

nificantly increased, thereby easing the burden which has been placed on the mental health staffs of correctional facilities.

2. Competent but Mentally Ill Prisoners

Eighty-five percent of all defendants examined at the prison wards for competency purposes are returned to the city correctional system as competent to stand trial. Some of these defendants are nonetheless severely ill and some are potentially suicidal. In 1973 there were 40 reported suicides in correctional facilities throughout the State of New York. Since many of these deaths could probably have been prevented if jailers in charge could have readily removed the disturbed prisoner to a therapeutic setting, a bill was passed recently which would allow for such a transfer. The bill, amending section 508 of the Correction Law, provides for the care and treatment of prisoners confined in a jail on either a civil case or upon a criminal charge. The legislation provides that a jailer or warden with the concurrence of a physician can remove a person who exhibits behavior that is threatening to himself or others from a jail to psychiatric facility approved by the Department of Mental Hygiene Law for involuntary admission. Unfortunately, since 5.6 individuals are required to man each guard post at the hospital (to cover 3 shifts a day, seven days a week), the procedures made possible may rarely, if ever, be used because of lack of manpower. Perhaps the procedure would be used more often if the responsibility for guarding these defendants was turned over to the hospital providing treatment, as is done under Section 730 of the CPL when a man is found incompetent to stand trial.

It is therefore recommended that the legislation be amended to provide that the Department of Mental Hygiene facility having secure quarters or city prison ward utilized, supply the necessary security personnel during defendant's hospital stay.

4. Prison Mental Health Services

a. Introduction

The function of the Department of Prison Mental Health Services is, theoretically, to provide mental health services to the prison and detention population of the City of New York. However, because of gross understaffing and lack of funds, the Department is effectively unable to maintain treatment programs, such as individual or group therapy, occupational therapy and vocational training, in the various correctional facilities under their jurisdiction. Instead, the major work of the Department has been, what may be characterized as, crisis intervention or reactive therapy; the treatment of symptoms rather than the attempt to effectuate a cure.

Technically, the Department regulates all prison mental health providers of services in the City of New York for which the State Department of Mental Hygiene has issued operating certificates. The state supplies program analysts who visit the prison facilities and make recommendations to the City Department authorities.

b. Departmental Jurisdiction

The Department of Prison Mental Health Services is a sub-agency of the Department of Prison Health Services of the City of New York. Prison Health Services is presently under the jurisdiction of the Department of Health.

Originally the Department of Prison Mental Health Services was under the administrative jurisdiction of the New York City Department of Corrections. The director of psychiatric services and the senior counsel for prison mental health, however, were salaried through the Department of Mental Health of the City of New York (now the Department of Mental Health and Mental Retardation Services). The reason for this bifurcation was that the two major salaries of the

Department, when paid through the Department of Mental Health, were partly reimbursed by the state under the Mental Hygiene Law.

In November of 1971, by executive order, the Mayor placed the Department of Prison Health, both professionally and administratively, under the jurisdiction of the superagency, the Health Services Administration. The Commissioner of the Department of Prison Health as of that time remained responsible for the professionals within the Prison Health Services. The Director of Psychiatry and Senior Counsel of Prison Mental Health stayed on the payroll of the Department of Mental Health and Mental Retardation.

On July 1, 1972, the Mayor, by executive order, placed the Department of Health under the jurisdiction of the Health Services Administration.

On July 1, 1974, by agreement between the Commissioner of Corrections, the Commissionner of Health and the Mayor, all prison health services, including mental health services, were placed under the professional and administrative jurisdiction of the Department of Health. Professionally, the Director of Psychiatry and the Senior Counsel are now under the jurisdiction of the Department of Mental Health and Mental Retardation. They are, however, still under the latter agency's administrative jurisdiction (on their payroll). All monies for the Department are, for accounting purposes, routed through the budget of the Department of Mental Health and Mental Retardation.

Recently, there has been a changeover in the hierarchy of the Department which has caused confusion and some dissension among departmental employees.

c. Mental Health Staffs of the Various Correction Facilities

Each facility in the correctional system has a number of psychiatrists, psychologists, social workers, therapists and mental health workers, assigned to it by the Department. The number of employees

varies, in most instances, according to the inmate population of the institution. For example, the Brooklyn House of Detention, with a census of approximately 800 inmates and an institutional capacity of about 840 has nine part-time psychiatrists who provide a combined total of 110 hours of psychiatric services per week. The Queens House of Detention for Men houses approximately 520 inmates. Five psychiatrists are employed there who provide a combined total of 34 hours of psychiatric services per week (many mentally ill were transferred to Queens and thus the lesser need for psychiatric service). In the Bronx House of Detention there are several part-time psychiatrists providing about 76 hours of psychiatric service per week for an inmate population of approximately 450.

The Branch Queens House of Detention, before being closed by the courts, was to eventually function as the city prison and detention system's psychiatric hospital. It had a capacity for treating some 43 inmates in the special observation area. Employed there were 16 part-time psychiatrists providing some 132 hours of psychiatric services, an obviously greater number of hours per patient then at the other institutions in the correctional system. The staff of Branch Queens is to be transferred to those Rikers Island facilities where the inmates have been transferred.

Rikers Island Hospital—another institution utilized by the Department—although called a "hospital" is actually an infirmary. Its license to be run as a hospital was taken away years ago. It does not have urine or blood serum analysis equipment or X-ray machines that a hospital such as Bellevue, Kings County or Elmhurst have. The Rikers Island facility, therefore, cannot conduct laboratory tests such as lithium carbonate blood seriology tests required when that drug (lithium carbonate) is in use.

The "hospital" has an open dormitory for potentially suicidal defendant-patient. The facility employs some activity program on the dorm, making it a quasi-therapeutic setting.

The third floor houses the extremely schizophrenic, assaultive, aggressive patients. This area of the "hospital" contains 52 cells, 26 on each side of the building, 13 cells to a wing. Some of the cells are presently non-functional because defendants have broken their toilet apparatus. Only 42 of the cells are therefore used.

There are part-time psychiatrists employed who provide approximately 141 hours of psychiatric services per week.

The adolescent Remand Center on Rikers Island (C-74) maintains a screening process to detect mental illness. All admissions are given a specially designed questionnaire to complete under the supervision of para-professionals. Those individuals suspected of mental illness are then referred to a senior psychologist who in turn assigns the inmate to a member of the institution's mental health team (either a psychologist, social worker or mental health worker) and if believed to be necessary, to a psychiatrist.

This same type of screening procedure is carried out at the House of Detention for Men at Rikers Island (C-71), and the New York City Correctional Institution for Men on Rikers Island. The Adolescent Center, however, has provided the largest number of referrals in proportion to prison population since apparently wardens in other institutions are sometimes reluctant to report any and all "unusual occurrences" which may otherwise have provided some clue that an individual at their institution is suffering from a mental disease or defect.

Other correctional facilities providing mental health services are located within three of the city's municipal hospitals, Bellevue, Kings County and Elmhurst, in the form of Psychiatric Prison Wards.

The personnel of each hospital staffs the prison ward for medical and psychiatric purposes. Technically, however, four separate agencies of the city have jurisdiction over the ward for various purposes.

The Health and Hospitals Corporation has general jurisdiction over all municipal hospitals and thus that agency would appear to have primary control of the ward's administration. But the City Department of Mental Health and Mental Retardation funds, in part, all inpatient psychiatric services of the City Hospital system. Therefore, the funding of the ward for psychiatric purposes is channeled through the budget of the Department of Mental Health and Mental Retardation, only appearing for accounting purposes in the budget of the Health and Hospital Corporation. Since the Department of Prison Mental Health Services (a sub-agency of the Department of Health) has professional jurisdiction over all prison mental health services and since the ward is essentially a prison facility, Prison Mental Health has some control as well.

The major function of the psychiatric prison ward at the present time is:

1. To administer and evaluate court-ordered examination of defendants to determine their competency to stand trial, and
2. To provide emergency psychiatric services for inmates of the city prison and detention system (the services consist of usually of nothing more than chemotherapy [treatment with drugs]).

There are three prison wards in the City: Bellevue, Kings County and Elmhurst Prison Wards. The last of these three is for women and is essentially the same as the former two. Bellevue has been discussed earlier (see pp. 105 *et seq.*). Outlined here brefly, therefore, is the Kings County Ward.

The Kings County Prison Ward has a total capacity of 80 beds, almost all of which are currently employed for the court-ordered evaluation of defendants to determine their fitness to stand trial. Since December, 1973, when the Queens Supreme and Criminal Court

Clinics became operative, some 40 beds may be used for other purposes since it is believed, this number of cases per month may be handled in the clinics. The ward's other admissions consist of psychiatric emergencies from Brooklyn and Queens.

The use of the new Queens Court Clinic will permit in the future a total restructuring of the psychiatric program in the Kings County Ward. At present, a hospital setting is unavailable for many defendants from the Brooklyn Men's House of Detention and the Rikers Island Institutions.

The average stay of patients is believed to be six weeks; two weeks for fitness determination, two weeks to schedule and have a court hearing and two weeks between the court hearing and transportation to a state hospital.

Of 40 emergency cases some 25% (10 defendants) are expected to be returned to prison within one week.

Another quarter, it is estimated, will be returned to prison within two weeks, and another 25% will be returned within three weeks. The final 25%, because of their psychiatric condition, will become candidates for a fitness examination and will remain on the ward seven weeks (the same six week period those already ordered examined remain, plus one week to secure a court order for a fitness examination).

Each week, it is expected, the ward will receive approximately 20 emergency patients and 14 ordered to be examined, a total of 1770 admissions annually.

The treatment program for the ward is expected to include comprehensive diagnosis, assessment and formulations of a treatment plan, individual, group recreational and occupational therapy and social service assistance for patient's family, financial and legal problems.

d. Referrals to the Mental Health Staffs of City Facilities

Referrals in detention and correctional facilities are derived from the following sources: (1) questionnaire screening, (2) medical personnel screening, (3) observations of the nursing staff, (4) observations of aberrant behavior by the uniformed corrections officers, (5) the inmate himself [self-referrals are the most numerous], (6) defendants ordered examined under Article 730 are automatically referred, and (7) defendants returned from state mental hospitals as competent to stand trial are automatically referred.

The most severely disturbed patients are referred by correction guards. The guards are usually the ones who spot suicide attempts. Even those who make manipulative suicide attempts (cut themselves slightly in strategic areas of the body to draw attention to themselves rather than cause their death), must be reported by the officer to the mental health staff.

Referrals to the prison wards occur in the following manner: (a) the warden of the city correctional institution may have an individual transferred to a prison ward as an emergency (while at the ward the warden's staff there may write a report in support of the issuance by the court of a 730 order of examination); (b) defendants may be sent directly by the court to the ward for a competency examination; (c) a defendant may be sent directly to the ward for competency purposes; and (d) convicted prisoners may be sent to the prison ward for a determination of their mental status.

e. Prison Mental Health Services Aftercare Program

The aftercare program of the Prison Mental Health Services has been providing services for the past two years to both male and female ex-criminal offenders and trial individuals who have been discharged from the New York City detention and correctional institutions. The program's general aim is to help alleviate some of the fears of return-

ing to the community and to facilitate entry into various treatment and vocational programs. Particularly, its goals are:

1. To assist the clients in a transition from institution life to community based life;
2. To direct clients to resources for the purpose of rehabilitation;
3. To provide follow-up services to clients to ensure that they have made an adequate adjustment to their post discharge plans and facilitate changes in these plans if necessary.

Referrals to the aftercare staff come through the mental health unit located in each correctional institution. Intake workers have been designated, generally from the professionals of the mental health staff at each institution to screen all:

a. Patients under the care of the mental observation unit;
b. New admissions to the observation unit;
c. Inmates who contact the mental health staff; and
d. Referrals from other institutions, staff or some other source outside the mental health unit.

The intake worker, after evaluating each case, makes recommendations for the kind of service required. These recommendations are noted on Department forms and sent to the supervisor of the aftercare program located in the central offices of the Department of Prison Health Services at 311 Broadway.

A field worker also located at the central office is then assigned to the case. He is charged with the following duties:

1. Interview patients in the various detention and correctional institutions before discharge.

2. Meet with the appropriate intake workers to discuss case and insure a smooth transfer from the institution to post discharge facilities.
3. Locate appropriate facilities in accordance with professional evaluation and make arrangement for placement.
4. Contact attorneys, probation officers, and parole officers to make necessary arrangements for treatment outside any court proceedings that may be necessary to facilitate this process.
5. Make home visits and contact the patient's family.
6. Help inmates deal with various city and social agencies such as the Department of Social Services.
7. Counsel inmates and provide positive reinforcement by the use of supportive therapy.

The aftercare program's central office staff consists of 1 supervisor, 3 social workers, 2 nurses' aides, 1 addiction counselor and 5 mental health workers and trainees.

f. Patients Returning to the City Prison System from State Hospitals as Competent to Stand Trial

Defendants who have been found competent to stand trial by psychiatrists at state mental hospitals (see pp. 131 *et seq.*), are returned to the city prison system in the following manner:

1. The mental hospital sends a "Notification of Fitness to Proceed" to the court and the District Attorney who prepares the order to produce. (The court clerk has the order prepared if the return is from Mid-Hudson.)
2. The Assistant Commissioner of the State Department of Mental Hygiene in charge of forensic psychiatry, having received the information from the state mental hospital,

telephones the main office of the City Department of Prison Mental Health and informs officials there that the subject is to be returned to the prison facility of origin (the place the defendant was housed following his being arrested).

a. The Assistant Commissioner informs the Department authorities of the subject's present mental status and medication.

3. The central office of the Department of Prison Mental Health then contacts the local correctional facility's mental health team and relays the information.

4. A clinical summary is thereupon forwarded by mail from the state hospital to the central office of the Department. (The central office receives clinical summaries only from Mid-Hudson. None of the other state hospitals provide them with summaries as a matter of course.)

a. A copy of the clinical summary is forwarded to the prison or detention center. It arrives, most times after the inmate does, from the state hospital.

g. Recommendations Relative to the Department of Prison Mental Health's Staffing

The Department of Prison Mental Health Services has heretofore experienced difficulty in attracting well qualified professionals and para-professionals. The reason for this seems quite apparent.

Psychiatrists who work for the Department on a per hour or part-time basis are paid $17.30 for each hour they work. Considering the fact that competent psychiatrists make, on the average, two, three or perhaps even four times as much money as that in private practice, one need not guess why positions for psychiatrists in the city prison system are hard to fill. Full time psychatrists make about $24,000 a year in the Department. Unlike part-time psychiatrists, full time members of the staff get paid for sick days, vacation days and holidays. Yet, those who work on a part-time basis are capable of making a greater amount of money working for the Department because on a part-time basis they are able to conduct a private practice during the prime hours of the day. (Many part-time psychiatrists, moreover, are third year residents still attending school). Again, therefore, it is understandable why 96% of all psychiatrists working for the Department are part-time employees.

In addition to being underpaid, psychiatrists working in the city prison and detention facilities must perform their services in relatively depressing surroundings. Their work in the prison is essentially ungratifying. They rarely have time to interview patients for longer than a matter of moments. Comprehensive therapy programs for each patient are virtually non-existent because of the limited allocations of time, funds and equipment.

Some psychiatrists have been attracted to other higher paying city funded jobs. The city, therefore, may be said to be defeating its own program in this area.

Mental health workers are also severely underpaid. Trainees receive about five or six thousand dollars a year, mental health workers between seven and nine or ten, and supervising mental health workrs about eleven thousand dollars a year. And, as is true with psychiatrists in the system, the job of the mental health worker is ungratifying, since results of their work are rarely observed.

Psychologists, paid in the ten to twelve thousand dollar a year category also frequently turn to better paying and more fulfilling employment.

Exacerbating the problem now are budget cuts. Individuals who resign may not be replaced because job lines are being eliminated.

The obvious answer to the problem of staff attrition is a general upgrading of salaries of all Department employees so as to attract competent psychiatrists, prospective mental health workers, psychologists, social workers, nurses, patients' aides, nurses' aides, etc. In the face of austerity budgets such a suggestion seems at first blush unreasonable. There is, however, no viable alternative to added appropriations.

In addition, the training of mental health workers is relatively poor considering the importance of the worker's function, to wit, psychiatric screening and counseling. Formal training programs are virtually non-existent. In years past, a two week lecture course was offered but has since been discontinued. The majority of the training, therefore, is on the job—obviously at the expense of the inmates.

Increased salaries and job training, however, will not provide job fulfillment or gratification, that intangible element which may determine whether an individual remains or seeks new employment.

This element, it may be expected, will be provided by an expansion of the available treatment programs and the corresponding involvement of staff in ongoing processes of psychiatric therapy.

Unfortunately, what is more, not only has the failure to maintain adequate staffing within the correctional facilities had an insidious effect upon the quantity and quality of treatment provided there, but it has adversely affected the aftercare program as well.

In an amendment to aftercare procedure dated July 1, 1974, it was noted:

> "[T]he aftercare program's workload has been critically affected by the understaffing in the institutions caused by attribution and leaving no provision for replacement of staff who resign from the agency.

> To rectify this problem, we are training all aftercare staff to be able to make professional evaluations of the clients' problems and needs. Four of these workers (1 mental health worker trainee, 2 mental health workers and 1 nurse's aide) will be assigned to work in four selected institutions as intake workers.
>
> The duties of the intake worker will remain the same as originally outlined. The intake worker will not be required to perform in house duties such as carrying a regular caseload."

Prior to this time intake workers had been "generally professionals" (*to wit,* social workers, psychologists, etc.) and the mental health workers in the aftercare offices worked as the program's field workers. On July 1, 1974, the number of field workers was reduced by four. The former mental health workers were thereupon assigned to take jobs of intake workers: individuals formerly "generally professionals" who "evaluate, from interviews with patients and records, the discharge needs of the patient, including treatment, housing, education and vocational training," and who "summarize screening and evaluation findings and recommendation for treatment in weekly reports to the aftercare program for assignment of patient to a field worker." The jobs of professionals had to be filled, apparently, by non-professionals because of a lack of adequate personnel.

In light of the foregoing the following is recommended:

1. An overall upgrading of salaries for treatment personnel in the Department of Prison Mental Health Services to a level commensurate with that which is competitive with comparable employment in the private sector.

2. Training programs need be established for complete preparation of prospective mental health workers. In addition to an initial training program, a formal ongoing course of training should be utilized to keep workers informed of

developing areas of psychiatric knowledge and to review established procedures and psychiatric information.

3. Expansion of treatment programs in accordance with previous recommendations and involvement of staff in therapy, the aim being to make the prison setting as therapeutic a community as is possible.

5. Mid-Hudson Psychiatric Center

a. Introduction

Accused felons who have been adjudicated incompetent to stand trial pursuant to Article 730 of the Criminal Procedure Law are transferred from correctional facilities in the City to one of the State mental hospitals designated by the Commissioner of the State Department of Mental Hygiene. The actual duty of designating an appropriate institution is carried out by an Assistant Commissioner of the Department of Mental Hygiene for forensic matters.

Realizing that the Department of Mental Hygiene has a statutory duty under CPL Article 730 to see that defendant-patients remain amenable to the court's jurisdiction, the Assistant Commissioner, in the majority of cases, designates Mid-Hudson Psychiatric Center, the Department's secure facility, as the appropriate institution for custody and treatment of the mentally ill subject accused of a crime and committed under a Temporary Order of Observation (on both Temporary Order and Order of Commitment [see pp. 146 *et seq.*]).

Not only are alleged felons sent to Mid-Hudson on Article 730 commitment, however, but civil patients and incompetent misdemeanants who have become management problems at other mental hospitals in the state system are transferred to Mid-Hudson as well. There, they are treated until stable enough to be returned to their catchment area hospital.

b. Facilities

Following the adoption of the Criminal Procedure Law in September of 1971 (which provided under Article 730 for the confinement in Matteawan State Hospital, a correctional facility, of only those indicted felons who had been judicially determined by a superior court to be a "dangerously incapacitated person") the State Department of Mental Hygiene determined it was necessary to provide a secure facility for the care and treatment of extremely aggressive patients formerly housed in Matteawan State Hospital.

At first, Mid-Hudson was located on the grounds of Matteawan State Hospital in what is now called Building 21 (sse pp. 151 *et seq.*). Groups concerned with the rights of mental patients objected to the arrangement, and the Mid-Hudson operation was thereupon moved in January, 1973, to its present site in New Hampton, New York.

The New Hampton building complex, constructed around 1916, originally served as a prison. It was subsequently utilized by the Department of Social Services of the State of New York, as the New Hampton Training School for Boys. Prior to January of 1973, when the Department of Mental Hygiene took control of the complex, it had been used for approximately three years.

The hospital is situated on 85 acres of land (off Route 6 between Goshen and Middletown, New York) but only a small proportion of the acreage is actually used for the patients. The hospital houses some 300 to 310 patients in four separate buildings described below:

DENTON HALL, which serves as the administration building, contains the hospital's 14 bed infirmary, its seclusion area, ward 14, ward 13, the female's ward, and the main entrance to the hospital's interior courtyard.

The infirmary ward and the seclusion area are divided by a section of four or five hospital beds for severely disturbed and

assaultive patients. A therapist's aide maintains constant surveillance of patients placed there. The seclusion ward, adjoining the beds for assaultive patients, is comprised of some 10 to 15 locked rooms measuring approximately seven by fourteen feet inside. There are no furnishings in these rooms other than mattresses. In those cubicles having them, windows are screened with safety screening on the interior, and each cubicle door has a 12 inch square peephole with cross-pieces of metal barring which partially obstruct one's view in or out. Ward 14 also has small separate rooms for patients; the doors to these rooms, however, have been removed. Ward 13, for the female population was opened in September, 1974, and is similar in design to Ward 14. The hospital entrance area has an observation station from which a security officer electronically controls the locking apparatus on a metal cell-like gate. There is a small area past the main gate going into the hospital, in which two other doors are found. One opens to the fenced courtyard in which the entrances to two other buildings are found, the other to the locked stairway leading to Wards 13, 14 and the infirmary and detention seclusion area.

The Service Building, the entrance to which also faces the courtyard, houses the auditorium, recreational facilities, the mess hall, and patient's canteen and visiting area. The auditorium is used for religious services and occasionally for the showing of a movie or the presentment of live entertainment. (The staff is wary of allowing large groups of patients to gather so they do not use the auditorium more often than they do). There is a room of pool tables in the lower portion of the building. A gymnasium and a body building room are located upstairs. The mess hall and kitchen is also on the upper level. The visiting room, having a number of cafeteria style tables and chairs, doubles as a patient canteen.

Oak Hall, the entranceway of which faces the fenced courtyard, is three stories high and houses 120 patients, 40 to a floor.

Each floor is divided into a dormitory area and a day room each occupying one-half of the available space. The occupational therapy facility, with a census of 22 patients, is located in the basement.

Forest Hall is similar in structure to Oak Hall and houses the same number of patients. Its entrance, however, is outside of the courtyard area, but is connected to it by a fenced pathway.

The Academic School is a two story structure housing 32 of the elderly and disabled patients. A nurses' station and meeting room, which functions as the hospital's courtroom for retention hearings, are located in the lower area. The patients' dormitories and a Mental Health Information office occupy the upper portion.

Denton Hall, Oak Hall, and the Service Building are connected by a 16 foot fence topped by barbed wire, which runs from the corner of one of the buildings to the corner of the next, such that the fence, in combination with the buildings themselves, forms an enfenced courtyard. Forest Hall is outside of this courtyard, but is surrounded by a series of fences which continue to run along the sides of a pathway leading to the main courtyard.

In addition to the patients' quarters, there are a number of garage and powerhouse buildings, staff quarters, an enclosed swimming pool and a fire house in which one fire truck is stored. The security officers man this firefighting equipment to extinguish most of the minor fires at the hospital. The New Hampton Fire Department assists when needed. All alarms are returned by telephone to the security office,

c. Security

1. Historical Background

In January of 1973 when Mid-Hudson was opened at New Hampton, New York, the institution's main buildings, Oak Hall, Denton Hall, and the Service Building were connected by a 16 foot high chain

link fence topped with three horizontial strands of barbed wire. Forest Hall, located outside of the main courtyard area, was connected to it by a walkway bordered by 8 foot high chain link fences topped with 3 strands of barbed wire. Patients in groups of 30 or 40 (an entire ward), were escorted from Forest Hall to the cafeteria in the service building for meals and to the service building and general courtyard area, for recreational therapy and other treatment programs, by two or three ward attendants.

Between February and May of 1973, 11 patients escaped, most by jumping the relatively low fences connecting Forest Hall and the yard, while on their way to meals and activities.

To remedy the situation, a metal roof was constructed over the walkway abutting the top of the chain link fences running along the path. The barbed wire on the 16 foot high fences was also increased from 3 to 13 strands and a top section, which curves inwards towards the yard, was added.

Between May 2, 1973 and May 6, 1974, only one patient escaped. He never returned. At this point, the hospital authorities reasoned that they had solved the security problem, until a rash of escapes occurred involving 13 patients. Some climbed through the barbed wire by spreading it apart. Three attempted to climb the corner of a building by employing the foot and handholds—conveniently provided by the obtruding bricks of the building's facing—to escape by cutting the bars of the fence with a hack saw.

Immediately following these escapes, in June of 1974, the director of Mid-Hudson assigned ward personnel to man, 24 hours a day, observation posts located in 4 spots inside the courtyard fence. However, because another escape occurred, the number of posts was increased to a total of 12, and post locations outside the fence were added. Now, therapy aides stand in the cold and sit in cars both inside and outside of the fence; each post within shouting distance of the next.

All this, apparently, is a temporary measure. Workmen, in addition, have filled in with cement the brick facing of all walls comprising the interior barrier of the courtyard, and proposals have been made for further improvement of security facilities.

Within the various buildings housing patients, all wards are locked, as are the entrances to these structures. Indeed, while the patients are in the dayroom, the sleeping area is locked so as to avoid incidents between patients and possible escapes. All staff members carry keys.

Patients are not permitted to leave the wards unless they are either honor card patients (capable of functioning on their own within the controlled environment of the hospital) or are escorted by ward personnel.

2. *Security Personnel*

The institution has 11 safety officers who are responsible for patrolling the hospital grounds and staircases and who aid in the apprehension of escapees. The remaining security staff is comprised of security hospital chief treatment assistants; ward personnel who have essentially the same responsibilities as those of therapist aides in other state mental hospitals. In Mid-Hudson they supposedly have the added responsibility of seeing that no patient escapes. They carry out this duty by reporting suspicious activities or conditions conducive to escape and by escorting patients off the wards to and from treatment programs and meals. At the present time they have the added task of manning the observation posts around the courtyard fences. Also, they check visitors when they enter the institution and patients following visits.

3. *Who Escapes*

Rarely does a severely disturbed patient escape, since that type of individual is usually so disoriented or out of contact that he is unable to formulate a plan and carry it out. Sixty-five percent of all those patients who escape are believed to have been malingerers, or

were already examined and certified as competent to proceed to trial. Patients who have good contact with reality or know that they are about to be returned to court will be the ones who attempt to escape or who succeed in escaping.

d. Patient Treatment

Defendants arriving from various correctional facilities throughout the state and other local state mental hospitals, are processed in the admissions area. Other patients are photographed but not fingerprinted (although the Department of Mental Hygiene's policy Manual does provide for fingerprinting). They are then medically and psychiatrically examined, a file folder is prepared, and they are then housed in an appropriate ward or dormitory.

Psychiatric services are delivered by a number of professionals and para-professional employees. There are 8 psychiatrists, 1 clinical physican, 8 social workers, 6 occupational therapists, 6 recreational therapists and 21 registered nurses. In addition, there are some 158 treatment assistants who are grade 14 state civil service workers making approximately $10,000 a year. All assistants are required to have at least one year's experience in forensic psychiatric work. Senior treatment assistants are grade 16 civil service workers paid about $12,000 a year and supervisors range up to grade 20 on the civil service scale.

Each building of the hospital has a treatment assistant supervisor who coordinates activities in the building. There is one chief supervisor for the entire hospital.

At least one psychiatrist and one psychologist are assigned to a building which houses approximately 100 to 120 patients.

Programs consist of chemotherapy, group, and individual therapy, occupational therapy and recreational therapy. The type of therapy

depends upon the treatment team or group of professionals and para-professionals to which a patient has been assigned. Some team leaders stress group therapy, some employ treatment assistants in therapy, others don't.

e. Transfer of Patients Out of the Institution

1. Management Problems

Patients who have been admitted to the institution as a serious management problem are returned to the local state hospital from which they had been transferred when their behavior pattern indicates they are no longer unmanageable.

Some management patients who are in "wonderful" psychiatric condition will be returned home on the request of the director, with the arrangement that the local state hospital will designate an appropriate aftercare program.

(Since patients are transferred to Mid-Hudson from all over the state it would be difficult for the institution to conduct its own follow-up program situated as it is, so far from many of the areas in which patients reside).

In management cases, to accomplish the transfer, the director of Mid-Hudson sends a letter requesting transfer and a clinical summary of the patient's condition to the Assistant Commissioner in charge of forensic matters. The Assistant Commissioner will then issue the order of transfer where he deems such a transfer appropriate.

2. Temporary Order of Observation: Non-Serious Crime

A small percentage (2 to 3%) of those patients transferred to the hospital on a Temporary Order of Commitment have been charged with relatively non-serious crimes. Although chronically mentally ill, they may, in fact, be harmless. These individuals are therefore trans-

ferred, immediately following admission, to a local state institution for the balance of the 90 day order.

3. Improper Order of Observation

Another small number of patients admitted, because they had been sent to Mid-Hudson on a Temporary Order or Order of Commitment issued on a misdemeanor charge (a clearly impermissible disposition under the law), are returned immediately to the appropriate local catchment area hospital.

4. Temporary Order: Found Competent

Patients committed under Temporary Orders of Observation who are determined to be competent to stand trial (before the termination of their order) are readied for return to court pursuant to the following procedures.

Referrals for an examination to determine fitness to proceed to trial come from many sources: (a) the hospital treatment team to which he had been assigned and which evaluates patients once a month; (b) other staff members who suggest to the psychiatrist involved that an individual may be competent; (c) the patient himself who indicates he is ready to face courtroom proceedings; (d) a parent or other relative of the patient may request that the patient be examined in the hope of finding of competency will bring a speedy disposition of the case; (e) the court or the District Attorney may request that a patient be examined so that if competent, he may be brought to trial; (f) a treatment team member may at a general staff meeting bring up the name of a patient he believes is competent.

A minimum of 2 staff psychiatrists then must examine the patient (sometimes 3 or 4 psychiatrists do). If the defendant is found competent to stand trial one of the examining psychiatrists dictates a clinical summary and has a Notification of Fitness to Proceed prepared. The clinical summary and Notification of Fitness to Proceed goes to the director of Mid-Hudson who signs the fitness form and has the original of both the summary and notice mailed to the court and copies to the District Attorney. A cover letter and a copy of the clinical summary is also sent in New York City cases to the New York City Department of Prison Mental Health Services. The Sheriff or, in the City of New York, the Department of Correction, then takes custody of the defendant and transports him in Correction vehicles to the appropriate correctional facility.

5. Temporary Order of Observation: Improved Mental Condition

Some patients under a Temporary Order of Observation will be psychiatrically evaluated and found, because of their good mental condition, transferable to a local state hospital to remain there for the duration of the Temporary Order. In this event, the hospital will notify the District Attorney by telegram 48 hours prior to effecting the transfer. If they have not received a response within 48 hours they assume there is no bar to the transfer, unless the charges are extremely severe in which event a telephone call will be made to the District Attorney's Office.

6. Temporary Order of Observation: Termination of Order Without Notification of Indictment

Patients on a Temporary Order of Observation who have not been indicted and have not gained competency to stand trial prior to the expiration of the 90 day period of the order are either transferred from or retained at the institution pursuant to the following guidelines.

Usually 48 hours prior to the termination of the Temporary Order of Observation the hospital will have a telegram sent to the office of the appropriate District Attorney. The District Attorney may respond by indicating he will not seek an indictment in the case, in which event the patient will be psychiatrically re-evaluated and if necessary be

treated as a civil in-patient. These patients, however, will be designated with rare exception to the Mid-Hudson Center.

The District Attorney may on the other hand inform the hospital that there is an indictment already outstanding, in which event the patient must be returned to court, and arraigned on the indictment.

In ten to fifteen percent of the cases the District Attorney does not respond to the telegram. According to an agreement reached by the local D.A.s and the Attorney General, the judiciary and the hospital will assume no indictment has been returned if they do not receive a response to their telegram within 48 hours. The period before which the hospital will consider some type of disposition varies with the severity of the charges (it may be some 15 days before the hospital decides to act). If the charges are extremely serious the hospital will send another telegram or a letter to the District Attorney informing him of the situation and requesting instructions on how to proceed.

At the end of the 90 day period of the Temporary Order of Observation, a Certificate of Custody is issued to the court by the director on behalf of the Commissioner and a copy is sent to the District Attorney. (This terminates the lower court's charges, see pp. 146 *et seq.*).

Again, by the above-mentioned agreement between District Attorneys, the Attorney General's Office and the hospital, no transfer will be requested by the hospital for a period of time to determine whether the District Attorney will act.

Once it is determined no further criminal action will be taken, the patient is psychiatrically re-evaluated for placement. If further necessary treatment is required it will be provided in accordance with provisions of the Mental Hygiene Law. Those patients, with rare exception, will be designated to Mid-Hudson Psychiatric Center in the first instance.

7. Temporary Order of Observation: Indictment Before the Termination of Order

Patients committed under Temporary Order of Observation who are indicted prior to the termination of the 90 days of the order are returned to court for arraignment on the accusatory instrument.

8. Orders of Commitment and Retention

Patients committed pursuant to an Order of Commitment are housed at the hospital for at least one year in the majority of cases. Following the one year period (or whatever period of time is thought necessary) patients believed to be chronically mentally ill, but who are behaving in the institution in an acceptable manner, are recommended to the Assistant Commissioner for forensic matters for transfer to the local state hospital in the patient's catchment area. Those patients on Orders of Commitment who have been hospitalized for a substantial period of time and who, as the professional staff has determined, will not become competent to stand trial in the foreseeable future, are transferred to other state mental hospitals on a *Jackson* determination. Greater efforts apparently are made to return an indicted individual to a state of competency (of course the staff, given the longer time period provided by the length of the Order of Commitment, have more flexibility in proposing types of treatment than they do with patients on the shorter temporary order). Apparently, also, patients on Orders of Commitment who have been charged with homicide or a serious assault are generally the easiest for the hospital to handle (usually most, if not all of the patient's hositility has been expended in these cases in the perpetration of the crime). In the close to three years the institution has been in operation, only 5 individuals charged with a homicide have been returned to local mental hospitals while still committed pursuant to an Order of Commitment. So far in 1974, 9 to 11 indicted patients have been transferred to Bronx Psychiatric Center. (The patient on an Order of Retention may be re-

tained, if he does not recover competency, for a period equalling two-thirds of the maximum sentence for the highest class of felony charged in his indictment).

f. Elopement Reporting

When a patient, either transferred to the hospital as a management problem or pursuant to an order issued under Article 730 of the CPL, elopes (escapes or takes leave without consent) the following procedure is employed.

The employee who discovers the patient's absence reports the fact to the supervisor's office. The supervisor then determines from a card catalogue kept in the supervisor's office and from the patient's medical files in Denton Hall, both the type of court order, if any, under which the patient has been committed or is being retained, and the physical description of the patient. This information is passed on to the police through the hospital switchboard operator, to the chief treatment assistant, and to the director of the institution. Staff then commences a search of the hospital grounds.

g. Recommendations Relative to the Mid-Hudson Psychiatric Center

1. Overcrowding

Because of the Matteawan legislation, the Department of Mental Hygiene will have to make room in its present facilities to hospitalize those mentally dangerously incapacitated patients formerly housed at Matteawan State Hospital (see p. 153 for further discussion). Plans are now being made to increase the present bed capacity of Mid-Hudson Psychiatric Center, one of two of the Department's secure mental facilities, from 300 to 400. (At the time of this writing it is unclear whether these plans for expansion will be carried out in view of the opening of Building 21).

It is anticipated that Oak and Forest Halls will be renovated to accommodate the increased population. As constituted, the Oak and Forest Hall's floor space is divided in half, one side of the building on each floor serving as a dormitory, the other side as a dayroom. It is expected that each half of those buildings' floors (measuring 93 by 32 feet) will be devided in half, one part to be used for a dormitory with beds for 25 patients, the other to serve as a small dayroom. In this manner, 50 patients will be housed on each floor, an increase of 10 over the present census of 40 per floor. Adding 30 patients per building, the renovation is estimated to make 60 more beds available. The infirmary, now being used primarily as a holding or admissions ward (because of overcrowding), will eventually be moved from Denton Hall to the Service Building. The old infirmary area will then be used as a ward for an additional 20 patients. What is more, the academic school building has been renovated for patients' use and will house another 32 patients.

The institution will be crowded when the structural alterations have all been completed in preparation for the Matteawan transferees. Present programs and treatment facilities will also be taxed by the larger number of patients.

One would expect that the acquisition and use of Building 21 at Matteawan will help to relieve some of the burden of overcrowding which Mid-Hudson has already experienced in small measure. However, the fate of Building 21 is as yet unclear since Mid-Hudson, originally located in this same Building 21, was closed and its operations moved to its present site because of the adverse publicity it received. It was seen by many critics as nothing more than another Matteawan with a Department of Mental Hygiene sign on the door.

It is recommended that the search for another building either to replace Mid-Hudson or to act as an addition to it be continued.

2. *Security*

Security at Mid-Hudson has also been a problem, as evidenced by the incidence of escapes from the hospital. A security consultant of the Department of Corrections has been called in to examine the facilities of the institution and make recommendations. Some suggestions in fact have already been made. A few have even been acted upon.

For example, concertina barbed wire on the tops of all fences has been suggested, as has vertical strips of barbed wire every three or four feet along the barbed wire already in place. This last proposal has recently been approved by the Department of Mental Hygiene and the contract granted. Safety screens on all windows has also been recently approved and the contract granted.

Some critics have proposed guard dogs and guns. Others have suggested that the courtyard front gate system in Denton Hall be improved by the addition of a second gate and a metal detector at the entranceway. (Engineers are drawing plans for implementation of this idea). It is also anticipated that fences will be added from the main courtyard to the swimming pool area, thus establishing the added security of two fences on one side of the courtyard.

For all that has been said and done about security at Mid-Hudson, however, the rate of escapes from the institution has been surprisingly low. Of the 1900 admissions since the hospital became operational in 1973, 25 escapes have occurred, 1.3% of the number admitted. Of the 25 that escaped, only 5 are still at large, however, .2% of the entire number of admissions. Of course, this is not to say that had there not been as much security as there was and is, the escape rate would have been the same. The probabilities are that with less security more escapes would have been attempted and, in turn, more patients would have been successful.

However, from the evidence presented it is clear that those security measures taken at Mid-Hudson at the behest of Department of

Mental Hygiene authorities have been the products of the Department's reaction to public outcry and as such have been "stop-gap" in nature rather than long-range and well-planned. Plugging security leaks will prevent escapes via the means "plugged" and eventually, through periodic Departmental efforts, Mid-Hudson will perhaps become virtually escape-proof. But, the effect of such an approach upon the mental health of the patients may be negative. (Numerous fences and gates restrict the movement of patients within the hospital and in turn the availability to patients and hence the effectiveness of treatment programs). If the present philosophy of building another fence here, adding barbed wire there, continues to guide the actions of the Department soon only Mid-Hudson's name will distinguish it from Matteawan.

In short, it is our belief that the Department's approach to security at Mid-Hudson has been both inefficient, wasteful, and lacking in humanity and shortsighted.

(It is also evident that fences as close to the hospital buildings as they are, create better escape routes. Patients use not only the fences but the building's structure itself to effectuate their freedom. Some patients have used the bricks jutting out from buildings to help get over the fence, others have gone to roofs and still others have hidden behind buildings out of sight of security personnel and have used the building to visually cover their assent over the fences).

It is recommended, therefore, that the following measures be taken by the Department of Mental Hygiene:

1. All fences should be removed from their present locations and used in conjunction with additional fencing, if required, in the following manner.
2. Part of the hospital grounds which may be employed by the patient population of the hospital should be surrounded by either one or two chain link fences topped with strands

of barbed wire and whatever other reasonable combination of equipment designed to assure the containment of hospital patients.

3. A short distance from the fence on the exterior side of the hospital, reasonable landscaping should be employed. (As an alternative to landscaping either a hurricane type or slat fence may be constructed.)

4. All gate entrances and exits should have a small guard station manned by security officers.

5. Along the fence, at a set distance, security guards should observe the fence in small guard stations located both inside and outside the fence; each station having communication facilities connecting it with all other security offices and guard stations. (The station would also have 360° visibility and have entrances both inside and outside the fence).

6. Additional security officers with walkie-talkie's should be on patrol in the area between the chain link fence and the landscaping or second but lower fence. Patrol ought to be both on foot and by scooter or small patrol car.

7. At night, the fence should be illuminated, in sections, by sodium vapor lighting: each section under the control of a security officer at a designated guard station. There should also be an emergency auxiliary lighting system.

8. Anyone entering or leaving the institution should be identified.

In this manner, many patients will be permitted to use the grounds of the hospital under supervision. Unnecessary and debilitating restrictions on movement within the hospital need no longer be imposed on a large proportion of the patient population. And a substantial amount of the time spent by therapist aides making sure that all

doors are locked and gates closed could be devoted to treatment. Perhaps most important, patients wishing to escape could no longer hide behind buildings or on roofs or use the buildings' walls themselves for escape. If they desire to elope they would, with the fences moved back away from the buildings and in the open, have to cross open ground and climb a fence located in open ground: a fence constantly patrolled by hospital personnel whose view could no longer be obstructed by hospital buildings.

3. Delay in Returning Patients to Court

There is, at times, an inordinate delay between the determination of competency and the Mid-Hudson patient's return to court to face the charges pending against him. The delay is caused by the following hospital procedures:

1. Between the actual decision by the psychiatrist and the preparation of a clinical summary and notice of fitness to proceed as much as a week or more may pass depending upon the work habits of the psychiatrist and the availability of typists.

2. Another day or even a few days may go by before the director signs the notification form and has it sent by mail to the appropriate destination.

3. Several more days pass while the notification travels through the postal services.

4. It may take as much as a week for the assistant district attorney to have an order to produce prepared and signed by a superior court judge, and then have it executed by the appropriate authorities. Authorities in turn pick up the defendant a week or more after the date on which the order to produce was signed.

Frequently, patients sense that they have been found competent and are about to be returned to court. Consequently, during the interim between examination for competency and arrival of the authorities who will transport the defendant to correctional facilities, some patients attempt to escape; some with success.

To eliminate the delay in returning a patient to court it is recommended that the following procedure be adopted:

1. Immediately upon a finding of competency Mid-Hudson will transmit a telegram to the appropriate District Attorney and appropriate court, providing the name of the defendant, the indictment number, docket number, the charges, if known, and the names of the physicans who made the finding of competency.
2. The telegram will be followed by a telephone call one day later to assure that the information is received by the District Attorney or his designate and the court clerk.
3. The Notification of Fitness to Proceed will be mailed to the District Attorney and the court, when prepared and signed by examining physicians and director.
4. The court clerk will prepare an order to produce on the basis of the telegram, or telephone call, having the defendant produced within 3 calendar days (not including Saturday, Sunday or legal holidays) of the date on which the order to produce is signed.
5. When the Notification of Fitness to Proceed is subsequently received, it will be filed for record keeping purposes only.
6. The administrative judge of each county or district should authorize all judges to issue an order to produce patients confined in Mid-Hudson on the information provided by the clerk or the District Attorney and not require the production of the actual notification form.

6. Parole Mental Health

When a patient-inmate is conditionally released from Matteawan State Hospital, the Department of Mental Hygiene is notified by the correctional institution and provided with a complete summary of information on the patient. If not considered dangerous, the patient will be sent to a catchment hospital. If dangerous, the patient will be transferred to Mid-Hudson Psychiatric Center for evaluation, treatment and appropriate subsequent disposition. Standard admissions procedures are carried out by the mental hospital, but the parole officer remains responsible for the patient for parole purposes during the period of hospitalization. The parole officer must be notified of any change in patient status.

The New York City area has one office for the referral of mentally disabled parolees who are not conditionally released directly into a mental institution. This office, located in Manhattan, is headed by an Area Director of the New York State Department of Correctional Services. The remainder of the staff consists of 1 senior parole officer, 2 parole officers and 6 part-time psychiatrists salaried by the Department of Mental Hygiene.

The psychiatrists there examine parolees, and parole officers refer the parolees to appropriate psychiatric services.

Parolees who are psychotic or have proven records of violence and act out may be recommended for hospital commitment. When such an individual has acted out and has violated parole in the process, the parole officer has a choice either to seek hospitalization or consider the action as a violation of parole. In such latter event, the parolee, following a parole hearing, and a finding of violation, will be returned to prison.

a. Recommendation Relative to Parole Mental Health: Coordination of Services

Coordination of aftercare services and referral services, by the mental health coordinator as suggested herein (pp. 156-57), will have a beneficial effect upon the type and quantity of care and treatment received by parolees. With an overall view of available services, the coordinator's office in the City of New York would be able to select the program most suitable to the parolee and, at the same time, maintain liaison between the Department of Correctional Services in the City, the Department of Mental Health and Mental Retardation facilities, *i.e.,* voluntary and municipal hospital services, the private clinics and programs and the mental health aftercare services of the Department of Prison Mental Health and the Department of Mental Hygiene.

PART THREE

VIII THE MATTEAWAN LEGISLATION

A. Introduction

On May 30, 1974, Chapter 629 of the Laws of 1974 was signed into law by the Governor. The "Matteawan Bill", as it came to be known, mandated that all non-convicted mental patients must be transferred out of Matteawan, a mental institution run by the Department of Corrections, by April 1, 1975. Clearly based on the humanitarian interest of treating non-convicted mental patients in civil mental institutions, the bill was passed to bring New York's statutes into line with recent court decisions.

The "Matteawan Bill" is commendable in theory and should have beneficial results in its long-range effect on the treatment of mentally ill defendants. However, the bill has caused many problems in the Bronx and elsewhere throughout the state. These problems were caused because the bill was passed without any preplanning to determine whether the Department of Mental Hygiene had adequate facilities to house and treat the Matteawan transfers and because no funds were attached to the bill to pay for such facilities.

These problems manifested themselves when local facilities such as the Bronx Psychiatric Center received violent and assaultive patients that it could not handle or contain within its wards. The transfers caused fears in the other patients, the staff and the community surrounding the Bronx Psychiatric Center. The press and government officials demanded that the District Attorney of Bronx County look into the situation.

After the bill took effect, the Department of Mental Hygiene expanded Mid-Hudson Psychiatric Center, its own secure facility, and acquired Building 21 at Matteawan in response to the problems caused

by the bill. Furthermore, Bronx Psychiatric was forced to tighten its own security and increase its capacity to handle violent patients. The Matteawan Bill was passed for good reason yet there is still doubt today as to whether the plight of the mentally ill defendant will be relieved by its implementation.

B. Department of Mental Hygiene Procedures Prior to May 30, 1974

Article 730 of the Criminal Procedure Law governs the examination of defendants to determine whether they are competent to stand trial. It also covers the procedure for commitment of defendants found incompetent to stand trial. A defendant is incompetent to stand trial if as a result of mental disease or defect he lacks capacity to understand the proceedings against him or to assist in his own defense.

Prior to May 30, 1974, when indicted felons were examined for capacity to stand trial, the examining psychiatrist was also required to state his opinion as to whether the defendant was "dangerous" or not. Then if the court found the defendant to be a "dangerous incapacitated person" he could be sent to Matteawan by the Department of Mental Hygiene. Chapter 629 changed that result in that the issue of dangerousness is no longer in the hands of the court. Now, if an indicted felon is found to be an "incapacitated person", he is committed to the custody of the Department of Mental Hygiene and they must treat him in one of their facilities. If the Department determines administratively, through its internal procedures, that he is dangerous they will send him to Mid-Hudson.

The remainder of the procedures for dealing with incapacitated defendants has remained the same even after May 30, 1974. When the issue of a defendant's competency is now raised before any criminal court, that court issues an "Order of Examination" to a director of a mental hospital who designates two psychiatrists who examine the

defendant. They issue an "examination report" setting forth their opinion as to whether the defendant is or is not incapacitated. The examination must be conducted where the defendant is being held in custody or if not in custody, on an out-patient basis. If the director informs the court that hospital confinement is necessary for an effective examination the defendant may be hospitalized under guard for a maximum of 30 days, extendable by court authorization for a further 30 days if the court is satisfied of the need for such extension.

If a lower court finds that a defendant is incapacitated, it must issue either a "Final" or "Temporary" "Order of Observation." When the accusatory instrument is other than a felony complaint, the lower court must issue a "Final Order of Observation" committing the defendant to the custody of the Commissioner of Mental Hygiene for a maximum of 90 days. If an indictment is not filed during this 90 day period, the Commissioner must certify to the court and to the appropriate District Attorney that the defendant was in his custody on the date of the expiration of the order. Upon receipt of this certification, the lower court must dismiss the felony complaint filed against the defendant, the District Attorney may, at his discretion, obtain an indictment any time within six months of the expiration of a "Temporary Order." If no timely indictment is filed, all proceedings on charges listed in the complaint are terminated and any further prosecution of the charges is barred.

When indicted felons are found to be incapacitated the superior court issues an "Order of Commitment." The order lasts for 12 months or until the defendant has regained his capacity, whichever occurs first. The defendant must be retained in a civil state mental hospital. Prior to May 30, 1974, the Commissioner could send the defendant to Matteawan if he was found to be a "dangerous incapacitated person."

At the expiration of the commitment order, if the defendant is still incapacitated, the superior court may issue an "Order of Reten-

tion." The first "Order of Retention" lasts for 12 months and all subsequent "Orders" run for 2 years. A defendant may only be retained under these orders for two-thirds of the maximum time for which he could have been sentenced on his highest charge.

When the defendant is in the custody of the Commissioner upon expiration of any of the above orders the director of the institution where the defendant is detained has 30 days within which to civilly commit him under the Mental Hygiene Law.

1. Transfers to Matteawan

Prior to May 30, 1974 dangerously incapacitated defendants were sent to Matteawan. Indicted felons who became dangerous after commitment on an "Order of Commitment" were transferred to Matteawan following an adjudication of dangerousness pursuant to statutory procedures.

Those misdemeanants committed under a "Final Order of Observation" and civil patients believed to be dangerously mentally ill were transferred to Matteawan pursuant to procedures of the Mental Hygiene Law.

Furthermore, defendants acquitted by reason of insanity who became dangerous while confined in a local mental hospital were transferred to Matteawan pursuant to procedures established by the Mental Hygiene Law.

Following adoption of Chapter 629 on May 30, 1974, the only people who can be sent to Matteawan are defendants convicted and imprisoned in a state or local correctional facility who are dangerously mentally ill.

2. Transfers from Matteawan

Dangerously incapacitated defendants originally designated to Matteawan, whose condition warranted it, were transferred either to Mid-Hudson or their local hospital for the duration of their "Order of Commitment." Those criminally accused and civil patients transferred to Matteawan following a separate adjudication of dangerousness, were, when their mental condition warranted it, transferred to either Mid-Hudson or their local hospital for the duration of their commitment.

3. Transfers to Mid-Hudson

All dangerous and non-dangerous unindicted felons committed under a "Temporary Order of Observation" were designated to Mid-Hudson in the first instance. Indicted and unindicted felons under "Orders of Commitment" and "Temporary Orders" who were designated to local state mental hospitals and who become management problems, were transferred to Mid-Hudson.

Civil patients found to be management problems in state mental hospitals were transferred to Mid-Hudson and were returned only when they no longer caused problems. Furthermore, defendants acquitted by reason of insanity who became management problems while confined in state mental hospitals were transferred to Mid-Hudson.

Those defendants designated to Mid-Hudson or transferred there as a management problem were transferred, when their mental condition warranted it, to their catchment area hospital for the duration of their commitment.

4. Method of Transfer to and from Matteawan and Mid-Hudson

The staff at Matteawan, Mid-Hudson and all local facilities evaluated the patient's mental status on a regular basis. If the staff determined the patient was a proper candidate for transfer, they would send

a report containing all relevant psychiatric clinical data, together with a written request for transfer to the appropriate official in the Department of Mental Hygiene.

The appropriate official would then review the material and study the entire clinical record and word notes. In Matteawan cases, that official would interview the patient personally, discuss the case with the professional and para-professional staff and after careful study authorize the transfer by signing a departmental order of transfer.

C. Legislative History

Following the Court of Appeals' ruling in *Matter of Kesselbrenner*, 33 N.Y.2d 161 (1973), officials in the Department of Corrections and in the Department of Mental Hygiene, reasoned that the constitutionality of sections of law pertaining to the transfer of non-convicted mentally ill persons to Matteawan was in serious doubt. This belief among high officials in both Departments was based in part upon the fact that the language of the Mental Hygiene Law that was held unconstitutional in *Kesselbrenner* had been incorporated virtually intact into various other statutes authorizing the transfer of mentally ill defendants to Matteawan. With the fall of the sections in *Kesselbrenner* it was believed, that other similar sections would likewise face a constitutional demise. Further reasoning by other officials was based on the decisions of *Jackson* v. *Indiana* [406 U.S. 649 (1972)]; *People* v. *Lally* [19 N.Y. 2d 27 (1966)]; and *Baxstrom* v. *Herold* [383 U.S. 107 (1966)]. They felt that because of those decisions it was only a matter of time before the courts would hold that only convicted prisoners could be incarcerated in Matteawan.

Thus, officials of the Department of Correctional Services, having discussed the matter with the Department of Mental Hygiene officials and heads of legislative committees involved in the area of mental health and corrections, decided the Department would sponsor a bill which

would in effect close Matteawan to all mentally ill persons other than those convicts who became mentally disabled while incarcerated.

Officials in the Department of Corrections drafted certain sections of the bill and supervised the preparation of the legislation. Since the proposed legislation was a "departmental bill" it was screened by the Governor's Office prior to being sent to the legislature. This screening was done and then the bill was sent on to the legislature.

On February 26, 1974, the bill was introduced into the Senate as Bill No. 8792, and was sent to the proper committee. The committee staff checked to see if there were available facilities for the implementation of the legislature. The staff learned that there would be some increased costs to the Department of Mental Hygiene. Since the Department could utilize Mid-Hudson, no appropriation was made for implementation of the law. The legislation was briefly discussed in committee and reported out on March 17, 1974. The bill passed in the Senate on March 25, 1974, without any floor debate.

Following the bill's passage in the legislature the Department of Mental Hygiene expressed its opposition to the bill because no money was allocated for its implementation.

On May 30, 1974, the bill was signed into law as Chapter 629 of the Laws of 1974.

D. The Aftermath

1. Facilities

Prior to the enactment of the "Matteawan Bill" legislators studying the proposed change in the law believed, quite correctly, that the Department of Mental Hygiene would have to be given some time to designate state hospitals for the housing of transferees from Matteawan. Indeed, that was one of the reasons why the time delay (until April 1, 1975) was incorporated into the bill itself.

Another reason for the April 1, 1975 date, however, was that the Department of Mental Hygiene would need time to alter its Mid-Hudson facilities to accommodate the transferees. But the Department (as well as the Department of Correctional Services) sadly miscalculated the available bed space for dangerous patients in mental hygiene facilities.

There were, at the time the statute became effective, approximately 100 defendants who would have to be transferred out of Matteawan. The Department of Mental Hygiene estimated there would be another 110 to 120 "dangerous" patients in need of hospitalization during the year, prior to April 1, 1975. It was further anticipated that Mid-Hudson could be renovated so as to provide a sufficient number of beds in Department of Mental Hygiene facilities for Matteawan transferees and all future "dangerous" patients. Unfortunately, during the first full month following the enactment of Chapter 629, the Department had to designate 103 persons to Mid-Hudson, 40 more than they expected. Planned provisions for the expected increase from 300 to 400 patients at Mid-Hudson was therefore inadequate.

Also, because of the large number of new admissions to Mid-Hudson following enactment of Chapter 629, many patients who should have remained longer in Mid-Hudson, were transferred to local facilities. In turn, these local mental hospitals (particularly Bronx Psychiatric Center) having inadequate security facilities in which to house numbers of potentially dangerous patients, were forced to treat these persons as best they could. These Matteawan transfers caused many problems at the local institutions where they were sent. They were assaultive and many escaped quite easily from the relatively unsecure facilities. Understandably, the staff, other patients and the surrounding communities became fearful.

In late August and early September, numerous newspaper articles dealing with elopements at state mental hospitals appeared in New York newspapers disclosing the passage of the Matteawan legislation.

Because of a lack of public hearings, Senate or Assembly floor debate, or general discussion in the community had been virtually unheard of prior to that time.

Legislators began to speak out against the situation in the local hospitals, pointing to the incidents of elopement and transfers of "dangerous" patients. In an attempt to correct the situation, one Senator, accompanied by one of his staff, set out to find a secure facility in the state in which dangerously incapacitated could be housed. After driving around the state in their car, they discovered that Building 21 of Matteawan Hospital at the Fishkill Correctional Facility was available. It is interesting to note that in 1972, Building 21 was used by the Department of Mental Hygiene as the Mid-Hudson Psychiatric Center, which was subsequently moved to an old boys' training school in New Hampton, in 1973.

The possibility of transferring jurisdiction over Building 21 from Corrections to Mental Hygiene was then discussed with Corrections officials. It was determined that Building 21 could be treated as a separate facility since it has adequate space for treatment, eating, programs and administrative offices. It has a capacity of 300 beds and its security level is medium which makes it appropriate for the treatment of dangerous mentally ill defendants.

Accordingly, the Governor's staff looked into the feasibility and desirability of transferring Building 21 to the Department of Mental Hygiene. On October 8, 1974, it was decided that Building 21 was the best choice to meet the state's needs for secure facilities for mental patients and a press release was issued announcing that decision.

Building 21 is designated to house patients who are dangerous or difficult to manage because of their psychiatric difficulties or because they have criminal charges pending against them. This new facility should relieve the over-crowding at Mid-Hudson. It should stop the

flow of dangerous patients to local institutions where they are ill-equipped to handle such patients.

2. Procedural Ramifications

After the *Kesselbrenner* decision and repeal of the section of the Mental Hygiene Law which that case declared unconstitutional, the Department of Mental Hygiene was left without a procedural mechanism for the tranfer of dangerously mentally ill civil patients in a civil state hospital to a secure facility. Mentally incapacitated defendants can now be designated to any institution in the Department that the Commissioner deems appropriate. This may be altered since equal protection would seem to mandate similar procedures and treatment for criminally accused patients under the reasoning of *Jackson* v. *Indiana* and *Baxstrom* v. *Herold.*

The Department has therefore proposed a set of regulations, which are in the process of being formally promulgated, for the transfer of dangerous civil patients to Mid-Hudson Psychiatric Center.

There are no procedures for the transfer of dangerous incompetent defendants to Mid-Hudson. The Department may soon have to promulgate rules, however, to afford incompetent defendants equal protection.

It is assumed that the procedures designed to transfer patients in and out of Mid-Hudson will also apply to Building 21 as soon as it becomes available for patient occupancy.

PART FOUR

IX LONG-RANGE PROPOSALS

In the following and final section of this report are three subsections with proposals addressed to the entire range of problems that exist in the field of mental health services for the criminal defendant and convict. These proposals are therefore grouped here rather than in some other section of the report concerning specific problems or difficulties.

A. Aftercare

Comprehensive follow-up services for the mentally disabled defendant returned to civilian life are indispensable in helping to bring about a reduction of criminal recidivism at least with respect to such recidivism resulting from mental illness.

The Department of Mental Hygiene aftercare program has had numerous difficulties with follow-up care because adequate resources have not been allocated to such services.

The importance of a restructured and well-financed state aftercare program to provide sufficient services to the mentally disabled defendant released from Bronx Psychiatric Center cannot be stressed enough. Good aftercare programs may ultimately reduce the criminal patient input into the Bronx Center and thus alleviate one source of the hospital's problems.

City Prison Mental Health aftercare services showed to be expanded, morever, to insure that mentally disabled defendants released from the city correctional system have available to them appropriate psychiatric services, including vocational training. Assuming aftercare will work to reduce the number of mentally ill recidivists, the expenditures for expansion of aftercare may well prove to be less than the

expenditures for provision of correctional services to the same mentally ill person, several times over. Aftercare on release from city correctional facilities will also function, it may be expected, to reduce the number of individuals who eventually end up at Bronx Psychiatric Center through either the civil or criminal process.

It is recommended, therefore, that more resources be made available by the State to assure adequate and appropriate aftercare services for those involved in the criminal justice process who become institutionalized in a state facility.

It is also recommended that the City's Department of Prison Mental Health Services aftercare program be expanded.

B. Commissioner in the City of New York to Coordinate All Mental Health Care and Treatment for the Mentally Disabled Defendant and Convict Confined in or Released from Correctional, Detention and State Mental Hygiene Facilities in the City

In New York City there are numerous private clinics and inpatient programs, voluntary and municipal hospitals with psychiatric services, prison mental health services and state programs of various types and descriptions, all potentially available in varying degrees to individuals who have been arrested and are in a city correctional facility, detention center or released therefrom on their own recognizance, convicted and incarcerated in a city correctional facility or paroled or convicted and are receiving psychiatric care as a condition of their sentence. There is, however, no referral service on an official level in any of the five boroughs of the City, to serve all persons involved with the criminal justice process.

There is, in addition, no central agency to which groups may submit proposals for new programs devoted to psychiatric services for the mentally disabled defendant.

There is no body or board to coordinate the many private, state and city sponsored programs in existence. Officials in agencies in Brooklyn may be totally unaware of successful or unsuccessful programs and procedures being employed in the Bronx, and vice versa.

In general, information concerning the treatment and care of the mentally disabled defendant is rarely, if ever, interchanged between the many sectors of the system of services available, with the result being duplication of effort, waste, and overall inefficiency.

It's beyond cavil that coordination of all available programs for the mentally disabled defendant and ex-defendant, and a comprehensive referral system for all those categories of mentally ill previously mentioned is essential for efficient delivery of proper psychiatric care and treatment.

It is proposed, therefore, that an independent office be established for the coordination and referral of psychiatric services for the mentally disabled individual who becomes involved with the criminal justice process. This office would be jointly funded by the City and State of New York, but be independent of any existing city or state agency. Its allegiance, therefore, would be to no particular group other than the State or City government as a whole. It would have one central office with divisions in the various boroughs and its function should be all encompassing. It would be responsible for the referral of all mentally ill persons involved with the criminal justice process released from correctional and detention facilities and state mental institutions, to aftercare services; the development of prison programs to aid mentally ill defendants; the coordination of existing programs both private, state and city funded; and the dissemination of information concerning the mentally ill defendant to all sectors of the system of care and treatment available.

C. Forensic Hospitals

It was originally thought that Matteawan would be something less than a prison but more than a mental hospital. Unfortunately the opposite came to pass. Perhaps the rationalization employed by public officials in 1887 best explains why.

> "The commissioners (of the commission of the New Asylum for Insane Criminals) call the attention of the Legislature to the fact that buildings for the criminal insane require to be constructed in a more substantial and secure manner and otherwise provide with more expensive facilities for insuring the safe custody of patients than would be deemed necessary or even desirable for the ordinary insane. The walls require to be thicker and stronger, the window guards to be of steel or other metal that will reset the action of files, saws and other cutting implements; the doors, fittings, etc., must be heavier and the locks more complicated than would be required in a non-criminal asylum; also the airing courts or exercise grounds must be enclosed with masonry, whereas playgrounds for the ordinary insane need but a simple board fence or preferably, no enclosure at all."

[Rep. Comm'n on New Asylum for Insane Criminals (1887), N.Y. Ass. Doc. No. 48 10 11].

Indeed the plans for Matteawan included:

> "Two small, one story buildings especially constructed with reference to strength and security . . . for the isolation of certain class of vicious and dangerous lunatics, whose presence on the ordinary wards is a constant source of danger and anxiety to the more orderly and tractable patients, as well as to employees." [*Id.* at 13]

The notion that mentally ill individuals who have become involved with the criminal justice system are somehow more "dangerous" than other types of mental patients has persisted for years.

In addition, although run by the Department of Mental Hygiene and not the Department of Correctional Services as is Matteawan, Mid-Hudson Psychiatric Center, in response to public pressure spurred by patients' escapes has been moving in the "Matteawan" direction by the addition to and expansion of present security measures.

And now civil institutions, other than Mid-Hudson, in response to newspaper accounts of escapes, are more slowly returning to the closed door practice popular decades ago.

Unfortunately society it seems cannot divert itself of the notion that the only answer to the problem of the criminally insane is incarceration in a maximum security setting with provision for only the most minimal amount of freedom of movement possible.

Nonetheless, there appears to be some glimmer of hope for the future. The Department of Mental Hygiene has been involved in various research projects in the form of experimental forensic units at Hutchins Psychiatric Center and at the Buffalo Psychiatric Center. (Another is planned for Albany).

The units proposed for in-patient and out-patient services and their research programs are long since overdue. The logical extension of the idea of such hospital units is the construction of forensic hospitals located throughout the state, all employing the peripheral security outlined earlier in the discussion of Mid-Hudson. With forensic hospitals in various parts of the state, forensic services may be available to all who need it. The forensic hospitals would deliver psychiatric services to all those found incompetent to stand trial, or acquitted by reason of insanity or held in pretrial detention who require in-patient treatment for psychiatric disorders while confined.

It is recommended that the Department of Mental Hygiene commence plans for the construction of or conversion of existing facilities into forensic hospitals throughout the State with the aim of having such hospitals operational within a reasonable period of time, from the date of this report.

PART FIVE

X COMPENDIUM OF RECOMMENDATIONS

Recommendation No. 1

It is recommended that Law Enforcement Assistance Administration funds be secured for the implementation of the following recommendations.

Recommendation No. 2

It is recommended that a Commissioner in the City of New York be created whose independent office would coordinate available psychiatric services for the mentally disabled individual who becomes involved with the criminal justice system.

Recommendation No. 3

It is recommended that a right to treatment for all mentally ill individuals be legislatively established, and that all mentally ill individuals for whom commitment is thought appropriate, should be confined at institutions which have a phased-peripheral security capability.

Recommendation No. 4

It is recommended, with regard to Bronx Psychiatric Center, that a forensic unit be established to house all Article 730 and Article 330 patients who are not considered dangerous to themselves or others. Those considered dangerous should continue to be housed in the Intensive Care Unit. All charts of those on the forensic ward should be color coded and should be kept in one filing area, readily accessible to staff who in turn will then be able to quickly provide the court or the District Attorney with information concerning the patient. Once a forensic ward is established, off-ward activities can be made available to forensic patients by secure means because ward personnel and

security staff can devote as much attention to the criminal order patients as is necessary.

It is further recommended that a substantial number of additional beds be converted for intensive care purposes and that a commensurate complement of professional and para-professional staff be assigned to the unit. Patients' charts on the I. C. unit should be color coded so that the criminal patients can be differentiated from all other patients. A system should be established which permits the psychiatrist to communicate an order for handcuffs directly to the security office when a patient is transported from the I. C. unit. The turnbolt locks on the present I. C. unit should be replaced with other types of locking devices, the keys to which should be carefully inventoried and returned by employees at the end of each shift.

A chain link or slat fence should be built around the Bronx Psychiatric Center and security officers should be posted at entranceways.

It is also recommended that there should be additional security guards hired without endangering other staff positions. The security guards should be given more training and more vehicles. Furthermore, lines of communication between the security office and the rest of the staff should be improved. Security Officers need be on constant patrol of the hospital grounds and at least one security officer need be in the security office at all times.

Escape procedures should be made clear to all staff members so that everyone is aware of responsibility in the event of an escape. Following an escape, a formal inquiry by the hospital authorities should be conducted to determine the cause of the escape to prevent a similar occurrence in the future.

All criminal occurrences on the grounds of the hospital should be reported to the police regardless of the willingness of a complainant to make a report.

The internal key-box fire alarm system should be directly connected to the Fire Department. Also, the New York City Fire Department should be given enforcement power over state institutions in its jurisdiction so that the safety of patients in those institutions will be better protected.

Recommendation No. 5

It is recommended that a State aftercare program to provide sufficient services to the mentally disabled defendant released from Bronx Psychiatric Center be restructured and well-financed and that the City Prison Mental Health aftercare services be expanded.

Recommendation No. 6

It is recommended that the Boards of Visitors of the various state mental institutions be given more direct say in the workings of the institutions and that the Boards be composed of at least one private psychiatrist, psychologist, social worker and lawyer in addition to the lay persons and parents of patients from the community, and that local government officials be made *ex-officio* members of the Board.

Recommendation No. 7

It is recommended that a mentally ill individual arrested for an offense and awaiting disposition of his case, not be subject to confinement without being afforded treatment and that a procedure, particularized herein, be employed in Criminal Court whereby an alleged misdemeanant suspected of being mentally ill and otherwise parolable may be accorded the necessary in-patient or out-patient psychiatric care immediately after his initial court appearance, and whereby, in the appropriate instance, his case may subsequently be dismissed in the interest of continuing therapy.

Recommendation No. 8

It is recommended, with regard to Mid-Hudson Psychiatric Center that its peripheral security be corrected by moving its chain linked fence out away from the hospital and establishing guard stations at entrances and some form of patrol system around the fence.

To speed up the return to court of Mid-Hudson patients found competent to stand trial, the institution should immediately send the court and District Attorney a telegram followed by a telephone call with the defendant's information. The hospital should also send a Notification of Fitness to Proceed, but the court should be able to prepare the Order to Produce even before the Notification arrives.

Recommendation No. 9

It is recommended, with regard to the Bronx House of Detention, that all inmates be required to complete a psychological questionnaire, under the supervision of the mental health staff, to aid in the psychological screening of all new admissions to the institution. Comprehensive treatment programs should be developed for each inmate judged to be mentally ill, which should then be carried out by professionals and mental health workers. There should be additional psychiatrists and additional quarters for mental health staff. The mental health staff should have access to the Department of Mental Hygiene's central computer bank of information on prior state hospitalizations for mental illness. In addition, Bronx Psychiatric Center should send a clinical summary to the Bronx House of Detention upon the return of defendants found competent to stand trial.

Recommendation No. 10

It is recommended that police officers be trained to recognize symptoms of mental illness and be trained to administer a mental status examination.

Recommendation No. 11

It is recommended that the Police Patrol Guide Procedures No. 106-11 be amended to read as follows:

PROCEDURE: Upon observing an individual who at first seems to be mentally ill conducting himself in a manner which in a sane person would be disorderly or upon receipt of a written statement by a licensed physician:

1. Take into custody if not already in safekeeping.

2. [Conduct a mental status examination in a safe area (such as in the patrol car or back at the station house)].

3. [Upon determining that the individual is apparently mentally ill] call an ambulance. If none is available [and if still situated on the street] bring person to station house and make second call.

And that Police Patrol Guide Procedure No. 106-11 be further amended to read:

Upon observing an individual whom at first seems to be mentally ill conducting himself in a manner which if a sane person would [constitute a criminal offense other than a felony or Class A misdemeanor].

Recommendation No. 12

It is recommended that legislation which allows for the transfer of mentally ill defendants from city jails to mental hospitals for psychiatric treatment be amended to provide that the Department of Mental Hygiene, rather than the sheriff's department, supply the necessary security personnel to guard the defendant in the hospital.

Recommendation No. 13

It is recommended that a system of advancing psychiatric cases on the Supreme Court calendar be devised so that a competency hearing may be held as soon as the reports have been prepared. To eliminate delay between the examination at the clinic by the first and second psychiatrist, both exams should be scheduled for the same day in all cases. If that is not possible with existing staff, additional psychiatrists should be employed. To prevent delays in obtaining an independent psychiatrist to controvert or confirm a psychiatric report, the defense counsel or prosecutor should be required to obtain a psychiatrist within five days, who would then be ordered by the court to prepare a report within five more days.

Recommendation No. 14

It is recommended that the City's proposal for increased bed space for the mentally disabled defendant and prisoner in the new Bellevue building be adopted, to provide the needed facilities for the psychiatric care and treatment of this class of patient.

Recommendation No. 15

It is recommended that:

1. There be an overall upgrading of salaries for treatment personnel in the Department of Prison Mental Health Services to a level commensurate with that which is competitive with comparable employment in the private sector.

2. Training programs need be established for complete preparation of prospective mental health workers. In addition, a formal ongoing course of training should be utilized to keep workers informed of developing areas of psychiatric knowledge and to review established procedures and psychiatric information.

3. There should be an expansion of treatment programs and involvement of staff in therapy, the aim being to make the prison setting as therapeutic a community as is possible.

Recommendation No. 16

It is recommended that ward charges, as well as other personnel, be appointed after careful and extensive screening, and be periodically re-evaluated and tested, along with all other personnel, to ascertain continuing competence and familiarity with all relevant security and safety practices and procedures.

Recommendation No. 17

It is recommended that a pamphlet be compiled and distributed to all hospital personnel containing an explanation of all security and safety practices and procedures as well as procedures employed for patients committed under Article 730 and Article 330 of the Criminal Procedure Law.

Recommendation No. 18

It is recommended that each unit have a safety and security administrator responsible for seeing that all safety and security practices and procedures are understood and followed.

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