A REVIEW OF LIVING CONDITIONS

in Nine New York State Psychiatric Centers, May 1984

New York State
Commission on Quality of Care
for the Mentally Disabled

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Preface

In accordance with the Commission's responsibility under the State Mental Hygiene Law to review the operations and practices of mental hygiene facilities, the Commission has conducted a review of basic living conditions and environmental safety issues at Bronx, Manhattan, South Beach, Kingsboro, Pilgrim, Buffalo, Rochester, Middletown, and Binghamton Psychiatric Centers. The findings of the review, as outlined in this report, indicate that the expectation of quality care in the public mental health system is achievable, as demonstrated by certain islands of excellence in eight of the nine facilities. However, the report also revealed that living conditions in five of the facilities required immediate attention and redress by the Office of Mental Health.

A draft of this report on the Commission's review has been shared with the Office of Mental Health. Appended is an abbreviated response from the New York State Office of Mental Health to the draft report. An additional 400-page response, detailing specific corrective actions at each of the nine psychiatric centers, by the Office of Mental Health is available for review from either the Commission or the Office of Mental Health.

The findings, conclusions and recommendations of this report reflect the unanimous opinion of the Commission.

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Overview Statement and Recommendations

This review is an outgrowth of the Commission's statutory functions of visiting and inspecting mental hygiene facilities. Over the past six years, the Commission has repeatedly confronted significantly sub-standard living conditions in a number of wards of State psychiatric centers, particularly in urban areas of the State. While our advocacy efforts with facility directors and Commissioners have often been successful in ameliorating the most egregious conditions observed, the Commission has continued to find similar conditions in many of these facilities. In several instances, we have noted that, after initial corrective actions, once the spotlight has moved conditions are often permitted to revert to their previous unacceptable state.

Confronted with significantly deficient conditions, the Commission has also encountered a barrage of explanations of inadequate budgets and short-staffing, of bureaucratic roadblocks and an absence of accountability of staff, of responsibility without authority, and more. To be sure, there are kernels of truth behind each of these factors cited. Some of the environmental conditions <u>are</u> caused by aging physical plants that require significant

infusions of capital to correct. Some facilities are understaffed in certain areas. There is an inordinate amount of energy-sapping bureaucratic process in practically every area of facility operations. And, decision-making power is scattered through layers of a hierarchy both within and outside the facility. Correcting these overarching problems depends to some extent on decisions and values established further up in the hierarchy of government -- by Commissioners and budget officials and, ultimately, by the Governor and the Legislature.

But, to a considerable degree, the quality of life for patients and staff is determined by the priorities established at the site itself and by the skill of on-site leaders in translating abstract notions of quality into tangible reality. How else does one explain the islands of excellence that thrive in facilities and wards ostensibly governed by the same constraining forces that allegedly produce such dramatic counterpoints?

The Commission lacks the wisdom to determine what share of the State's available resources should be spent on the needs of people with mental disabilities. We respect the Governor and the Legislature for their annual attempts to sift through the seemingly unlimited demands

of competing claimants and to apportion these resources according to need, within the constraints of finite wealth. While we cannot provide meaningful advice on the division of the fiscal pie, the Commission believes it can contribute to a further understanding of the nature and dimension of the needs of the mentally disabled. We believe that a fuller appreciation of the day-to-day quality of life for patients in our State psychiatric centers will assist in more informed decision-making in the budget formulation process and, perhaps more importantly, in better priority-setting in the budget execution process. We also hope that such a presentation will focus broad governmental and public attention on the need to develop clearly understood and widely accepted expectations of a level of performance that must be achieved within State psychiatric centers in meeting the basic human needs of patients.

With these objectives in mind, the Commission conducted a structured review of basic living conditions in six randomly selected wards (excluding specialty services) of each of 9 of the State's 25 adult psychiatric centers. Influenced by the Commission's concerns over conditions in New York City facilities, the review focused heavily on State psychiatric centers

located in urban areas of the State. The nine facilities account for 45 percent of the State's 21,850 inpatients. They also treat 47 percent of all new admissions to State psychiatric centers. The review focused on 133 indicators of the quality of living conditions, many of them drawn from standards used by the Joint Commission on Accreditation of Hospitals (JCAH). Each facility was surveyed by a two-person team which spent three consecutive days in unannounced visits lasting from dawn to dusk. During this time, wards were examined, staff were interviewed, and a random sample of patients was interviewed as well.

What emerged clearly from this review is that there are at least nine different thresholds of acceptable living conditions present in the nine facilities reviewed. Indeed, so variable were the conditions witnessed among the 54 wards we inspected that no single generalization about the quality of living conditions for patients in State psychiatric centers is likely to be universally accurate. Thus, no claim is made that the findings of this effort reflect conditions prevalent in all State psychiatric centers. To be sure, variations in the quality of care provided by psychiatric facilities are to be expected, as with most endeavors in the human service field. What is startling, however, is that these

different thresholds do not, at most of the centers visited, reflect variations above a minimum standard, but in several instances affect the most rudimentary aspects of the obligation of a mental hospital to care for its patients -- to provide them with a clean, safe and sanitary environment; clean, fitting and seasonally appropriate clothing; nutritious and tasteful food; proper personal hygiene; and an opportunity to engage in meaningful and constructive activities.

Of even greater concern, and what does appear to be relevant to conditions in all nine State psychiatric centers at the time of our visits, is that each facility seemed to be free to establish its own threshold. There appeared to be little regular, systemwide accountability for meeting any minimal threshold of acceptable conditions.

It is apparent to any student of the public mental health system that it is trapped in a basic quandry -- as a provider of last resort, it must meet essentially limitless demands for service with finite and incommensurate resources. As evidence of this predicament, it should be noted that eight of the nine facilities we reviewed experienced significant overcrowding on a number of wards.

To a considerable extent, overcrowding is not within the complete control of the facility itself, at least partly because, unlike licensed hospitals which have limits on the number of certified beds that can be occupied, there is no firm ceiling on the number of beds that can be filled in State mental hospitals. As community hospitals send their excess patients to State psychiatric centers, unrealistic occupancy goals are frequently exceeded without adequate provision for commensurate increases in resources. The consequences are invariably undesirable although the degree of the adverse impact varies considerably among the facilities. Most severely impacted are the facilities in the New York City metropolitan area where the mental health system evidences all the stresses and strains which were described at some length in the report of the Governor's Select Commission on the State-Local Mental Health System-Subcommittee on New York City.

Overcrowding complicates the already challenging task of managing a public mental hospital. It has a pervasive impact upon the quality of life for both patients and staff, including a lack of privacy, greater friction between staff and patients and among patients, and a lesser ability to recognize the individual needs of patients. In the course of our review, we noted that, in

some instances, dorms designed for 25 patients were serving 30, 40 and even more patients. Single rooms had become triples. In some wards, so many beds had been crammed in that wardrobes could not be opened and doors were blocked off. Not infrequently, beds were a scant 12 inches apart. At five of the nine facilities, overcrowding had led to patients sleeping in kitchen areas, hallways, dayrooms and utility rooms, and at two facilities, patients were shuffled to various parts of the facility in search of a vacant bed for the night, leaving them with no place to call their own. In four facilities, wards were found to be without towels, leaving patients to dry themselves, after showering, with bedsheets and pillowcases. In eight of the nine facilities, a number of beds were often found without appropriate bed linen. And, in two facilities, underwear was in short supply, resulting in patients wearing the same undergarments for a week or doing without them entirely. In these facilities as well as in two others, clothing was generally in short supply with many patients dressed in shabby, unclean, and ill-fitting clothing, and some patients without shoes or socks. Finally, as a result of overcrowding, we found dining areas in three facilities were sometimes cramped and patients stood in long lines waiting to eat. Food was often cold, thus depriving patients of one of the few pleasures available to them.

Attentive management and vigorous attempts to appropriately reduce lengths-of-stay and increase discharges have enabled some facilities to cope reasonably well in providing decent care. But, in five of the nine other facilities, drab and dirty wards, bathrooms without soap, toilet paper or paper towels, toilets without doors or curtains, and numerous basic indignities to patients (including the lack of toothbrushes or underwear) were found. Such conditions often have become so much a part of life in these facilities that they seem to be scarcely noticed by staff. But they combine to erode dignity, self-respect, and a sense of identity from patients who come there needing help precisely in these areas to regain control over lives shattered by mental illness.

Compounding the impact of such conditions is the pervasive inactivity of patients in most of the wards we visited. Facility directors acknowledged that even the best of the facilities are usually unsuccessful in providing meaningful programs and activities to more than a small number of patients on some wards. Although this study did not focus on treatment of patients, the Commission staff were struck by the absence of professional staff on the wards and by the infrequent occasions, during the three days of our visits, on which ward staff were observed to be engaged in activity with the patients.

Most patients experienced stupefying inactivity, often with insufficient seating space during the day, leading idle patients to pass their days sleeping on floors, window ledges and bathrooms, shuffling aimlessly about dayrooms and corridors, or staring vacantly at the ubiquitous TV screen.

In three of the nine facilities, the Commission found even more direct threats to the health, safety and well-being of patients. Exposed wiring, pipes and plumbing fixtures protruding from walls and floors, filthy and slippery floors, seclusion rooms reeking of urine, bedrooms and kitchens infested with roaches, vermin and mice, staff inattention to obvious physical ailments requiring medical attention -- all these were observed during our review.

Yet, in eight of the nine facilities, the Commission also encountered a considerable number of caring staff whose daily attempts to cope with the diverse needs of large numbers of patients were nothing short of heroic. In the better facilities, their skills, dedication and passion blossomed under caring leaders and islands of excellence emerged. In the worse facilities, it is apparent that, if these caring traits once existed, they have been eroded into apathy.

It is imperative that the highest priority be assigned to eradicating the intolerable conditions described wherever they exist in the mental health system. It is not the conditions alone that warrant our attention, but the value systems that allow them to exist in institutional societies. It is perhaps worth observing that many of the conditions we found would violate constitutional standards to which convicted criminals have been found entitled.

There is hope, however. The deplorable conditions we found do not have to exist. This review uncovered exemplary approaches by some facilities to dealing with the same challenges, with similar constraints and despite the same formidable obstacles. Their successes are beacons of hope that the expectation of quality care in the public mental health system is achievable. Although the reductions in staffing have hit facilities hard in support areas such as maintenance workers and laundry clerks, four of the nine facilities, including the largest one in the State, were able to provide all the patients reviewed with appropriate, clean and well-fitting clothing. At three facilities, all patients reviewed had adequate personal hygiene supplies. Three facilities, including the

largest, had virtually no housekeeping deficiencies. And perhaps most encouraging of all, islands of excellence were found at eight of the nine facilities, including exemplary living conditions in some of their wards, day-rooms and dining rooms, and creative, albeit limited, efforts to provide programs and activities for patients.

The Commission thus believes that there is a capacity for quality care in the public mental health system -- a capacity that is inconsistently realized due to an absence of an overall sense of mission in some parts of the system, poor leadership and management, and ultimately an insufficient sense of accountability for performance. However, better management alone will not remedy all of the serious problems noted. It would be disingenuous to discount the role that tight staffing, scarce resources and unpredictable and unending demands for service play in making facility management a difficult, sometimes impossible, and often thankless task. It is apparent that additional resources are needed to correct the effects of long term neglect of repairs and maintenance of the physical plants, to develop services to ease the pressure of overcrowding and to shore up support areas in some facilities.

Additional resources alone are not enough, however. Many of the conditions witnessed among the 54 wards--the

lack of toothbrushes, soap and underwear; the absence of personal clothing, towels and bed linens; filthy bathrooms lacking toilet paper and privacy--are not caused by a lack of money or resources. The average annual cost per patient at these facilities is $41,651. Nor is there a lack of management ability in the mental health system to eliminate these deficient conditions. Rather the problem is a system that has turned a blind eye to these correctable conditions. They have endured because management has not prioritized these issues and addressed their eradication. Even absent an infusion of greater resources, improved care and treatment could be provided if expectations of performance were clearly explicated. Significantly, an unvarying expectation that basic needs of the patients must be met needs to be unequivocally articulated and universally realized.

It is critical that in this process the potential for patients to participate in therapeutic work activities be reexamined on a systemwide basis. Unduly restrictive notions about the proper responsibility of capable patients to attend to their own basic housekeeping needs has eliminated much possibility of patients helping to maintain their living environment. Thus, tasks that are

necessary adjuncts of daily living for most people (e.g., making beds, tidying up, doing the laundry, etc.), and tasks in which patients need to maintain their skills to function appropriately when discharged, are generally not required of them. As a result, the quality of life has suffered as pervasive idleness stretches endless hours of boredom while patients' living areas often remain in shambles.

The Commission believes it is essential that concerted efforts be made to provide patients with a sense of belonging, participation and responsibility. Consistent with that, there is an absolute need to find constructive activity, identified through targeted treatment plans, for patients to occupy themselves for most of their waking hours. Needless to say, care must be taken to ensure that such activities do not cross the line between permissive housekeeping and therapeutic work, and impermissible institutional maintenance labor.

In developing a mission statement for State psychiatric centers, the Office of Mental Health would be well advised to examine the OMRDD system and the impact of requiring "active treatment" on the overall quality of care of residents of developmental centers. It is the Commission's view that the articulation of clear goals,

such as specific time requirements for active programming each day, has facilitated improvements in the quality of life for such residents. Such goals provide a framework for developing rational staffing requirements and for measuring success or failure, however imperfectly. No such goals currently exist for the mental health system, leaving facilities and their patients vulnerable to the vagaries of the budget-making process and to the varying expectations of performance by diverse constituencies.

RECOMMENDATIONS

Based on these conclusions, the Commission offers the following recommendations to assist the Office of Mental Health in upgrading the quality of living conditions for patients.

A. Overall Recommendations

1. The Office of Mental Health should, as a matter of high priority, develop a clear and concise mission statement outlining minimum expectations of standards of care that all State psychiatric centers will achieve and maintain. This statement should specifically address the responsibility of these facilities to meet the basic human needs of patients, as well as to provide them with a minimum number of hours of constructive program or activity each day. Each facility should be annually evaluated by the Office of Mental Health against these standards of care and senior managers held accountable for their performance in these areas. Preferably, such evaluations ought to occur on an unannounced basis.

2. The Office of Mental Health should develop, on a priority basis, a policy that requires facilities to develop therapeutic treatment plans for patients which include therapeutic work activity addressing their needs to develop or maintain personal and self-care skills. Such plans may require that patients be given responsibility for housekeeping tasks in their living areas.

3. Every State psychiatric center should be surveyed to identify deficiencies in the physical plant that directly impact upon living conditions for patients. An inventory of repairs, maintenance and capital projects should be developed, prioritized and scheduled. In this process, consideration should be given to temporarily regionalizing maintenance staff to address the most critical problem areas in a timely fashion.

4. The Office of Mental Health should review the impact of reductions in work force upon facility operations which directly impact the quality of life for patients (e.g., food service workers, laundry clerks, recreation therapists, etc.) and, where necessary, request funds to operate at a level that meets the minimum standards of care identified in Recommendation No. 1.

5. Facility directors, deputy directors for institutional administration, and other senior managers who have demonstrated skill in meeting and exceeding acceptable standards of care should be used as resources throughout the system in an effort to upgrade performance in vital areas affecting day-to-day living in psychiatric centers.

6. The Mental Hygiene Law should be amended to add a bill of rights for patients who reside in institutional settings, along the lines of the recently enacted bill of rights for the mentally retarded and developmentally disabled residents of community residential facilities (MHL §41.41). The law should provide that such a bill of rights be posted prominently on every ward of every facility and that the poster contains information on how to contact the

facility Board of Visitors, the Mental Health Information Service and the Commission on Quality of Care if a patient believes his or her rights are being violated.

B. Overcrowding

To assist State psychiatric centers in reducing the level of overcrowding on their wards:

1. A high priority should be given to developing additional community residence beds in every catchment area of the State.

2. The Office of Mental Health should seek to establish domiciliary care facilities in each region of the State to provide housing and aftercare services to patients who are ready for discharge from psychiatric centers but for whom there are inadequate resources in the community. Suitable vacant buildings on the grounds of State psychiatric center campuses are an option that should be explored for this purpose, consistent with the model developed at Creedmoor Psychiatric Center.

3. The Office of Mental Health should seek to develop additional crisis residences to assist each psychiatric center to deflect potential admissions that do not necessarily require acute hospitalization.

4. Realistic program occupancy goals should be established for each psychiatric center, consistent with the resources available, to provide adequate patient care. For those centers that are currently above these occupancy goals, specific plans should be developed to reduce and eventually eliminate the overcrowding. One option that should be considered in the process is the transfer of consenting patients who do not have strong ties to the community to other facilities in the State providing equal or better conditions.

5. The Office of Mental Health should consider accelerated development of day hospital programs to reduce the pressures for inpatient psychiatric care.

C. Internal Monitoring

1. The Office of Mental Health should require every psychiatric center to create and utilize an internal review mechanism to periodically evaluate the facility against accreditation standards. Such evaluations ought to be conducted sufficiently frequently to ensure that standards are being continually maintained. Reports of these surveys should be made available to the facility director, the deputy director clinical, unit chiefs, and ward level staff, as well as the Regional Office and boards of visitors. The facility director should be held accountable for the implementation of any corrective actions identified as being necessary in these surveys.

2. Every psychiatric center should clearly establish personal accountability at the ward level and at the unit level for living conditions which exist. There should be a specified individual on each shift who is personally accountable for ensuring that living conditions comply with the minimum standards that are established.

3. To facilitate clearer communication and priority setting with respect to housekeeping and maintenance at facilities, each facility should establish periodic meetings of clinical staff and maintenance/support staff.

D. Miscellaneous

The Office of Mental Health should arrange for representatives from several facilities to meet with purchasing agents at the Office of General Services to make clear the special needs of psychiatric centers for furniture and patient clothing. The need for such communication is particularly acute with respect for furnishing requirements for secure units and other units that house aggressive, acting out patients.

Chapter I
Introduction

Over the past six years, and in the course of nearly 3,000 site visits to State psychiatric centers, the Commission has repeatedly witnessed living conditions which do not address patients' basic needs for clothing, appropriate personal hygiene, and a safe and clean living environment. In some instances these conditions have appeared on selective wards of a facility or have reflected a short-term deficiency, but in other cases these conditions have prevailed throughout the institution and have reflected a serious neglect of patients confined to fundamentally inhumane living environments.

When observed, these conditions have been reported to facility directors, the Commissioner of the Office of Mental Health, and, in some cases, the Governor's Office. These reports have spotlighted particularly deficient patient living conditions and have often prompted improvements. Unfortunately, however, in many instances conditions again deteriorate. More importantly, these individual efforts have led to little systemic improvement or sustained efforts to ensure that living condition standards for patients in State psychiatric facilities meet any minimum standard.

This review of patient living conditions in 9 of the State's 25 adult psychiatric centers was born out of the frustration of these individual efforts and recognition that State psychiatric centers cannot provide a therapeutic, rehabilitative environment for persons with serious mental illness without the provision of an environment that attends to their basic needs. The Commission recognizes that large congregate care facilities inherently have difficulty in meeting the individual needs of patients, and that State psychiatric centers, in particular, are faced with both relentless service demands and funding constraints. The Commission believes, however, that State psychiatric centers must provide patients a safe, clean environment which meets their needs for food, clothing, and personal hygiene.

Methodology

In conducting the review, the Commission used a uniform study instrument to assess conditions. The study instrument included 130 items assessing various living areas on a typical ward including dayrooms, bathrooms, dormitories, and seclusion rooms. Approximately 100 of the items directly reflected standards set by the Joint Commission on Accreditation of Hospitals (JCAH). JCAH accreditation is critical for state psychiatric facilities, as well as non-public facilities, because federal Medicaid and Medicare reimbursement is contingent upon accreditation.

The sample psychiatric centers included four upstate facilities, one Long Island facility, and four of the five New York City facilities. Influenced by the Commission's concerns over conditions in New York City facilities, the review heavily focused on facilities in urban areas of the State. The sample centers were:

Binghamton Psychiatric Center
Bronx Psychiatric Center
Buffalo Psychiatric Center
Kingsboro Psychiatric Center
Manhattan Psychiatric Center
Middletown Psychiatric Center
Pilgrim Psychiatric Center
Rochester Psychiatric Center
South Beach Psychiatric Center

Together the average daily census of these nine facilities (July 1984) was 9,770, or approximately 45 percent of the total census of the State's 25 adult psychiatric centers. The nine sample facilities also receive a disproportionate number of patient admissions, accounting for nearly 47 percent of the total State adult psychiatric center admissions in July 1984.

At each of the sample facilities, Commission staff visited six randomly selected wards. Specialty wards, like skilled nursing facility (SNF) wards, secure units, and adolescent units, were excluded from this sample to focus on those wards (admissions, intermediate, and chronic wards) where the typical adult inpatient was most likely to be placed. Because the sample facilities ranged in patient

census from over 3,000 patients at Pilgrim Psychiatric Center to 400 patients at South Beach Psychiatric Center, the percent of the facility patient census living on the six sample wards ranged from 5 to 42 percent. Among the nine sample facilities, the mean percent of patients living on the six visited wards was 21 percent, or slightly more than one-fifth of the patients at the facility.

On each of the sample wards the Commission also randomly selected four patients from ward rosters to determine whether individual patients had adequate clothing and personal hygiene supplies, and if their obvious medical needs were addressed. Where possible, we interviewed these patients to gain their views of living conditions on the ward. A standardized study instrument was used to capture these data on individual patients.

Observations at each facility were made by two Commission staff persons during a three-day period. All visits took place during May 1984. The Commission staff arrived early in the morning, approximately 6:30 a.m., and stayed at the facility until after the evening meal. Each of the six wards were visited on the first two days. Those wards with significant deficiencies were visited on all three days to ascertain whether the conditions noted were isolated instances of deficient care or more representative of daily conditions.

No claim is made that the study's findings are representative of the State mental health system. As will become evident in the next chapter, conditions varied greatly among the facilities and even among wards of the same facility. What is representative is the tolerance of the mental health system for the variety of conditions found.

It should be noted that the directors of each of the nine facilities received a written report from the Commission outlining in detail both the positive and negative aspects of the living conditions observed during our visits prior to the preparation of this report. These reports were also sent to the Commissioner of the New York State Office of Mental Health (OMH). Throughout July, August, September, and October, numerous formal briefings of conditions observed were also held with State psychiatric center directors, executive staff of the Office of Mental Health, and the Division of the Budget.

The responses of the directors of the nine facilities and the Office of Mental Health have, in many ways, been heartening. There has been virtually no debate regarding the accuracy or seriousness of the Commission's findings, or the imperative need for prompt correction of the deficiencies by the Office of Mental Health. In addition, preliminary plans of corrective action have, in many instances, addressed procedures designed to prevent the recurrence of cited problems.

Organization of the Report

Chapter II presents the findings of the Commission's visits to the nine facilities. The chapter is organized in several sub-sections including patients' personal needs; living environment concerns; issues affecting patients' health and safety; and general quality of life concerns, like patient idleness and patient privacy. The discussion of these specific issues is preceded by the Commission's findings related to overcrowding in the centers, a problem which had ramifications for and, in some facilities, appeared to contribute substantially to the serious deficiencies in basic living conditions that were noted.

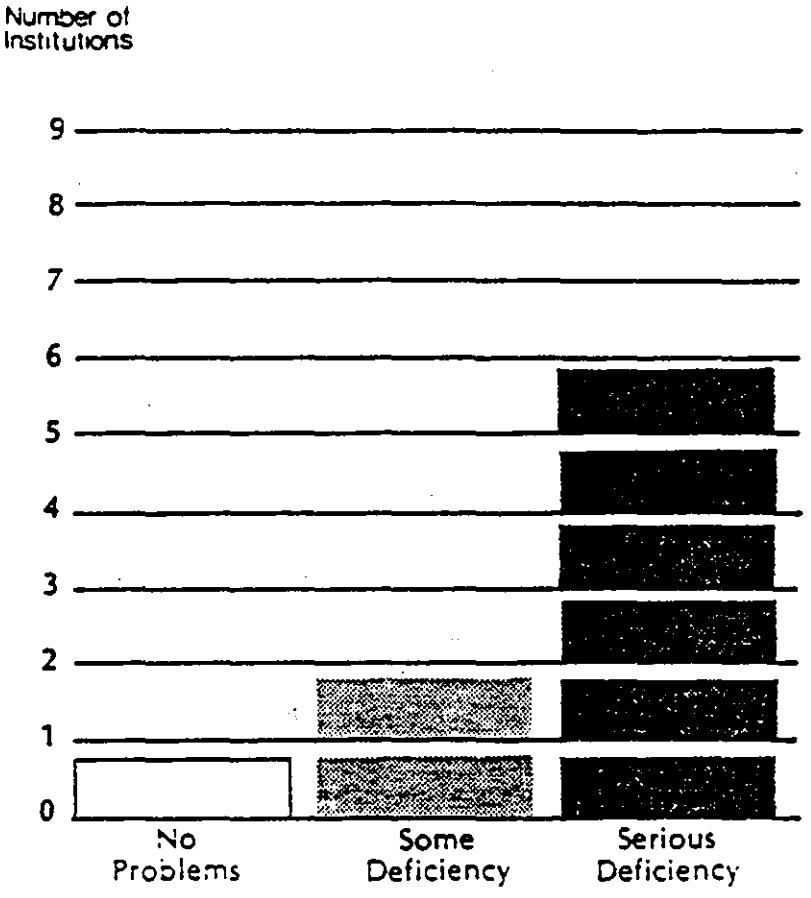
Throughout the presentation of the findings the significant variation in patient living conditions among the nine facilities and among different wards within the same facility is highlighted. In most of the visited facilities, these variations were striking. Some wards of State centers were found to provide excellent living conditions for patients and evidenced the diligent efforts of ward staff to provide environments for patients which clearly reflected the staff's respect and concern for patients. Other wards reflected serious and chronic neglect of patients' basic needs. These variations indicated the absence of any minimum standard of care in attending to patients.

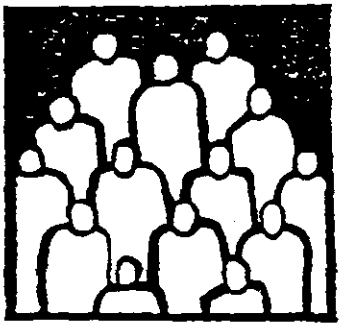
The Commission's conclusions and recommendations are outlined in Chapter III.

Chapter II
Conditions at the Nine Visited Centers

Trying to capture the essence of living conditions for patients in large state psychiatric hospitals is a difficult task. Trying to communicate in written words how the totality of these conditions impact on the quality of patients' day-to-day life in these hospitals is even more difficult. In this chapter, the specific observations of Commission staff, as they spent three days in each of the nine New York State psychiatric centers, are presented. The narrative relies on the simple presentation of findings, with little elaboration and stripped of our staff's personal reactions to the conditions they observed.

Notwithstanding this style, the narrative attempts to paint the picture. The reader, however, must put the colors and images of the following pages together to grasp the synergistic impact of the conditions observed on the overall quality of life for patients and staff alike, who spend time in these centers being cared for or doing the caring.





Overcrowding

Overcrowding, a problem at eight of the nine visited facilities, substantially impacted on the overall capability of the centers to provide attentive and humane living conditions for patients. Whereas at two facilities (Binghamton and Middletown) the overcrowding problem was observed on only one or two of the six visited wards, at the remaining six facilities (Rochester, Buffalo, Bronx, Manhattan, South Beach, and Kingsboro) overcrowding was

apparent on most or all of the wards, affecting the quality of life for the majority of the patients. Beds were frequently less than two feet apart and sometimes less than 12 inches apart. Dorms designed for 25 patients were serving 30-40 patients. Single rooms had become triples. In addition, at many facilities space in corridors, day halls, and even kitchens had been converted to space for beds. And, at Bronx Psychiatric Center virtually all convertible space, including a utility room, was being used for bed space.

On a number of wards beds were so cramped in dorms that wardrobes could not be opened, or dorm doors were blocked, or difficult to open. Dayrooms often lacked sufficient seats for patients and, in some cases, dining areas were cramped and patients stood in long lines waiting to eat in closely timed shifts.

Commission staff observations of the serious overcrowding at the six facilities clearly demonstrated its impact on patient life at these psychiatric centers.

Rochester: Overcrowding was a serious problem on five of the six wards visited. On these wards, beds in dormitories were close together, frequently less than one foot apart. Situations were observed where patients had to push their beds aside in order to open their wardrobes and take out their clothes. One dining room had insufficient seats for the patients being served (36 chairs for 40 patients).

Buffalo: Severe overcrowding was noted on all wards. Wards designed to serve 25 patients were serving 30-40 patients. Single bedrooms had become triples. Dormitory beds on all wards were less than two feet apart and some beds on all wards were less than 18 inches apart. Dayrooms were also overcrowded without enough seats for patients, and some patients were sleeping on the floor. Overcrowding in the dining areas resulted in cold food for patients waiting in long lines and in cramped dining areas.

Manhattan: Dormitories on three wards were very overcrowded with beds only 18 inches apart. On one ward the dayroom was much too small, with 30 cramped seats for 46 patients.

South Beach: Overcrowding led to beds less than two feet apart on two wards. Additionally, patients slept in one ward's kitchen area due to a lack of bed space in bedrooms on these wards. Due to this overcrowding, a number of patients on one ward had no lockers to store personal belongings. In addition, dayrooms on three wards had insufficient seats for patients. On one ward there were only 19 seats for 40 patients.

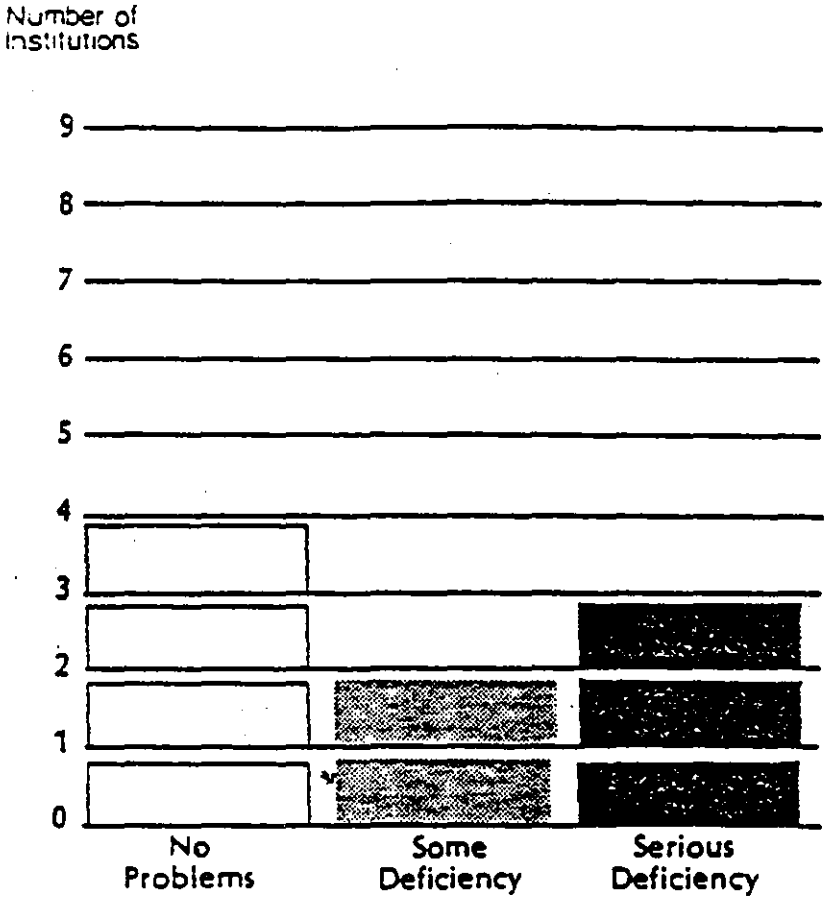
Kingsboro: On four of the six wards, overcrowding on dormitories was a significant problem, with beds less than two feet apart. On one ward seven beds had been placed in a common area because there was not sufficient space in the dormitory. In other dormitories, beds blocked doors and lockers.

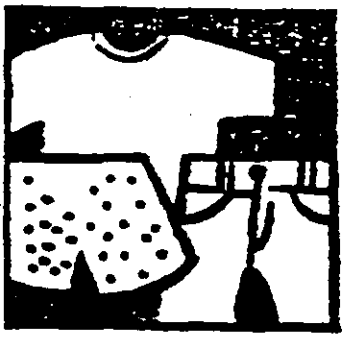
Bronx: There was less than 18 inches between beds on all wards. On two wards, patients were lodged out to other wards because there were not sufficient beds. Dayrooms and dining halls were crowded and sometimes were without an adequate number of seats for patients. The effects of overcrowding on the quality of life for patients were only too apparent. The many beds, particularly in small dorms, which were only inches apart; the sheer number of patients wandering the halls and squeezing into dining rooms that could not accommodate the entire ward population at one time, left patients without a sense of their own space.

The impact of overcrowding on all aspects of patient life at the centers was apparent to Commission staff, and was often reiterated by facility staff, as well as, on occasion, by patients. The overpopulated wards compounded the usual difficulties of a congregate care facility in attending to individual patient's need for clothing, personal hygiene and bathroom supplies, and adequate bed and bathing linens. Housekeeping was also substantially more difficult. But, perhaps most significantly, overcrowding contributed to staff burnout and/or indifference, as demands on ward staff seemed to exceed reasonable expectations with no limit in sight. As a result, overcrowding became both an excuse and a cause of the serious neglect of patients' needs that Commission staff witnessed in the three days spent at the facilities.

Patients' Personal Needs

The Commission review included a major focus on the facilities' ability to address the basic personal needs of patients, including their need for clothing, personal hygiene supplies, bathroom supplies, and bed and bathing linens. The visits revealed deficiencies in all of these areas at at least five of nine facilities. Notably, with the exception of Manhattan Psychiatric Center which had adequate bathroom supplies on the visited wards, all four New York City facilities had deficiencies in all the aspects of patients' personal needs examined.





Patient Clothing

Clothing for patients was a serious facilitywide problem at three facilities, Bronx, Manhattan, and South Beach Psychiatric Centers. It was a significant, although less serious problem at two other facilities, Rochester and Kingsboro. There appeared to be a scarcity of clothing at all five of these facilities, and at four of these facilities the available clothing was often ill-fitting, shabby, or not clean. Significantly, at the four other facilities (Middletown, Binghamton, Pilgrim, and Buffalo) all sample

patients were appropriately clothed in clean and well-fitted clothing.

The severity of the clothing problem at the four New York City facilities was easily observable. At these facilities there were minimal efforts to provide patients with personal clothing and, instead, patients received the luck of the draw from large clothing bins each day. Patients also complained about the lack of adequate clothing. One patient stated, "I don't have enough underwear and socks." Another, "I can only change my underwear once a week." Still another stated, "Everything is going all right so far, but I need a pair of shoes."

The findings of the Commission's review of the 24 randomly selected patients at each of the four New York City facilities dramatically illustrate the serious clothing problems:

South Beach: Many of the patients on two wards did not have sufficient clothing--only what was on their backs. Overall, 10 of the 24 sample clients were not wearing clean clothes on at least one day of the Commission's visits. Two (2) of the four sample clients on one ward wore the same clothes all three days. One, in fact, slept in these clothes.

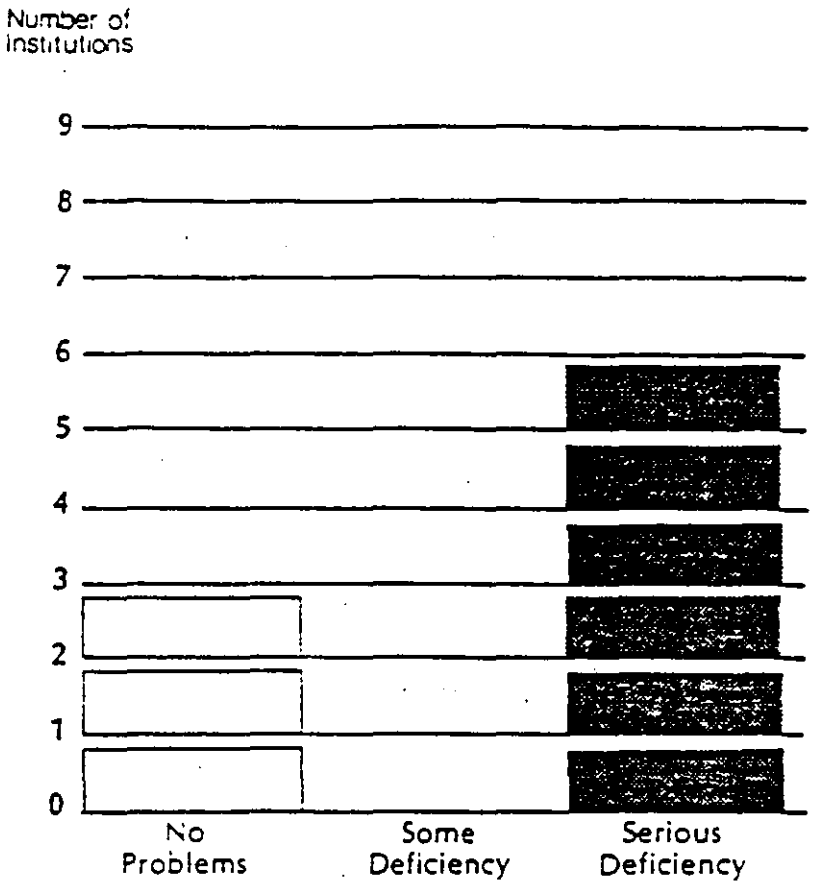
Kingsboro: Although all but 2 of the 24 sample patients were adequately dressed, few patients had more than one change of clothes and most only had the clothes on their backs. Almost all patients wore State-issued clothing. In fact, patients were discouraged from wearing personal clothing even if they had it, because management of individualized clothing was viewed as too much of a problem. Patients took State-issued clothing from bins in the laundry room each day--first come, first served.

Manhattan: A serious shortage of clothing was noted on all six wards. Clothing when available was often ill-fitting and badly wrinkled. Underwear was a luxury on two wards, where many patients were often forced to go without underwear and others were able to change underwear only once a week.

Bronx: Many of the 24 sample patients were poorly dressed in shabby, mismatched, and sometimes ripped and ill-fitting clothing during the three-day period. Patients wearing pajama tops or bottoms instead of shirts or pants were not uncommon. Patients who did not bring personal clothing to the facility got the luck of the draw from the clothing room each morning. Others were wearing clothing that was not seasonal; for example, furry winter boots, a wool overcoat during our late May visit; and still others wore no underwear.

The clothing problems we observed seemed to be a management problem. At many facilities, ward staff complained about inadequate and untimely distribution of clothing for patients. At several facilities, laundry procedures appeared ineffective and/or washing machines and dryers had been broken for some time. In addition, facilities varied widely in their storage systems for patient clothing. At Buffalo and Pilgrim Psychiatric Centers, where almost all patients appeared adequately dressed, for example, we found clothing rooms in which individual patient's clothing was neatly stored in patient-specific and labeled cubbyholes. In contrast, at other facilities we found clothing rooms to be in disarray with little care given to sorting and storing individual patient's clothes.

Overcrowding at several facilities had also sharply curtailed the availability of drawers and wardrobes for patients, and at Rochester and Bronx Psychiatric Centers we observed wards where patients' clothes were stored under beds or piled on top of beds, chairs, or wardrobes for lack of storage space.



Personal Hygiene Supplies

There was a serious shortage of personal hygiene supplies on most of the six wards of six of the nine facilities. Notably, at the other three facilities (Binghamton, Middletown, and Pilgrim) all of the sample patients had these supplies. The problems at the six facilities, however, were grave, with many patients without personal toothbrushes, toothpaste, combs, hairbrushes, or razors for shaving. For example, at Bronx Psychiatric Center patients without toothpaste were attempting to clean their

teeth with mouthwash. And, at Kingsboro Psychiatric Center it was common to observe patients trying to brush their teeth with their fingers for lack of toothbrushes.

At Buffalo Psychiatric Center many of the patients interviewed complained of having to borrow toothbrushes or not brushing their teeth for several days. On two wards, staff could not find any toothbrushes at the Commission's request. On one of these wards, staff also could not produce any toothpaste, hairbrushes, or razors. On another ward at Buffalo, only four toothbrushes were available for the more than 24 patients.

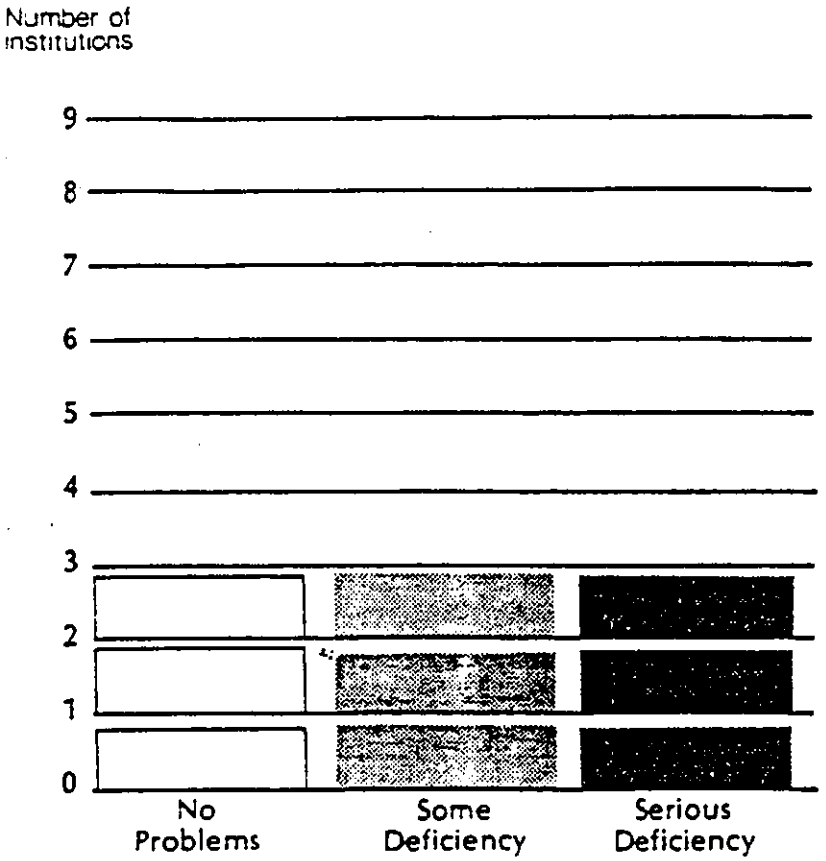
At Rochester Psychiatric Center, personal hygiene supply shortages were noted on four of the six wards. One-third of the 24 sample patients did not have adequate supplies (combs, hairbrushes, toothbrushes, etc.) and ward staff complained that they were not provided with adequate grooming supplies for the patients.

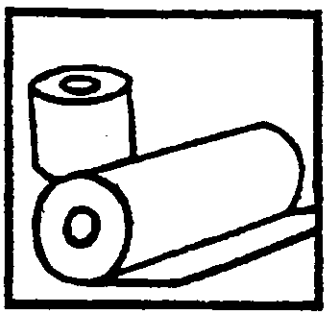
Of the 24 sample patients at Manhattan Psychiatric Center, half had no comb or hairbrush; all but two had no personal toothpaste; and all but five had no individual bar of soap. Razors were also in short supply on two of the three visited male wards with less than one razor per five to eight patients. Patients at South Beach Psychiatric Center suffered from a similar lack of grooming articles, with 7 of the 24 interviewed patients without toothbrushes, toothpaste, combs, and/or hairbrushes.

At Bronx Psychiatric Center staff and patients on all six wards reported that toothpaste and toothbrushes were often unavailable. Twenty (20) of the 24 randomly selected patients did not have a full set of basic grooming supplies (e.g., toothbrushes, toothpaste, combs, or hairbrushes). The four patients who did have supplies had brought their own.

At Kingsboro Psychiatric Center personal hygiene supplies were virtually unavailable for the majority of patients. Sixteen (16) of the 24 patients interviewed at Kingsboro during our visits had no personal hygiene supplies whatsoever.

Like the clothing issue, the issue of adequate personal hygiene supplies seemed to be primarily a management problem. Effective individualized storage systems for personal hygiene supplies, like those seen at Pilgrim Psychiatric Center, appeared to be the exception. Commission staff heard many complaints from patients and ward staff that hygiene supplies seemed to simply disappear either through theft, loss, or staff pilferage. Ironically, at Buffalo Psychiatric Center, where virtually no toothbrushes could be found on several wards, the director responded to the deficiency by noting that the facility actually had an adequate supply of toothbrushes, but they remained in a storage room, undistributed to the wards. He has indicated since our visit that this problem has been corrected.





Bathroom Supplies

Bathrooms lacked basic supplies at six of the nine facilities. At three facilities (South Beach, Kingsboro, and Bronx) these shortages of supplies reached critical proportions with many bathrooms without soap, many toilet stalls without toilet paper, and paper towel dispensers often empty. At all facilities, few patients had individual bars of soap, and the practice of all patients sharing the same bar of soap was common. Although many wards had soap dispensers to preclude the use of "community soap," the

dispensers were most often empty. Significantly, at the other three facilities (Rochester, Manhattan, and Buffalo), all bathrooms were well stocked with supplies.

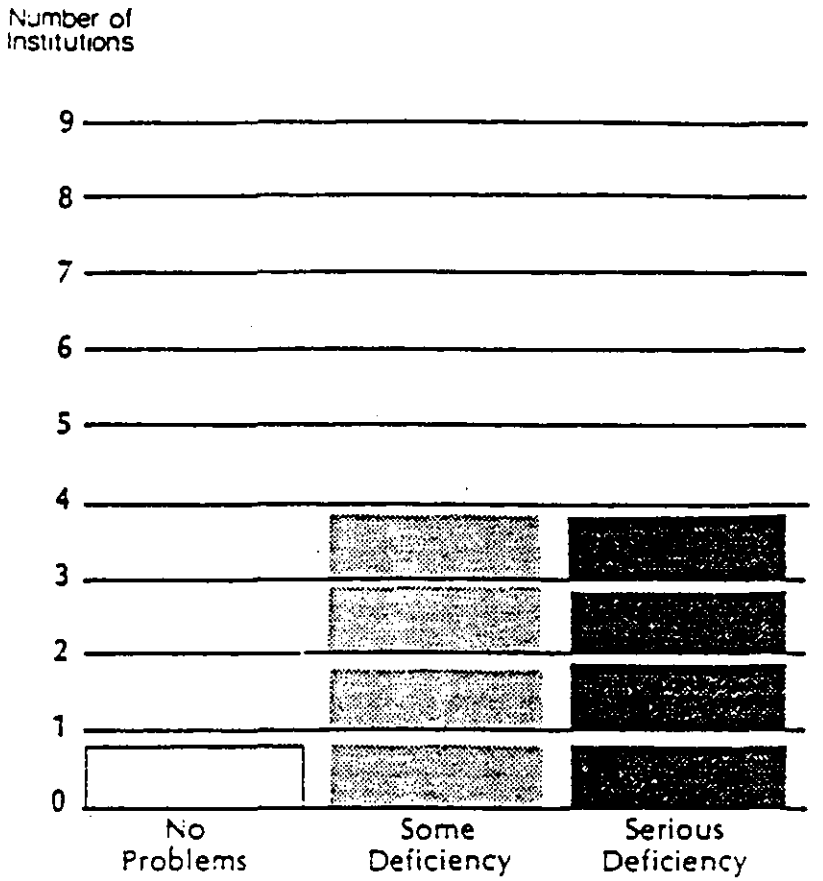
At South Beach Psychiatric Center, for example, several bathrooms on four wards were without toilet paper. There was no soap present in 5 of the 15 bathrooms on three wards.* None of the soap dispensers on any of South Beach's wards had soap. Similar problems were noted at Bronx Psychiatric Center where toilet paper was lacking in some stalls of all visited bathrooms on all three days of the Commission's observations. In addition, paper towels were absent on five of the six Bronx wards.

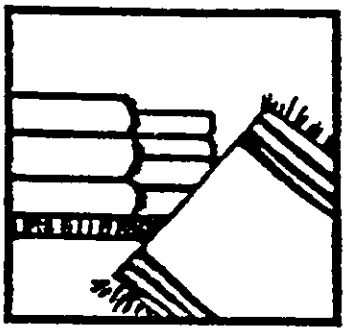
At Kingsboro Psychiatric Center toilet paper, paper towels, and soap were a luxury on most wards. Toilet paper shortages were noted on all six wards. Bathrooms on two wards had no toilet paper at all. On two wards there was no soap. One ward's bathroom had no soap, toilet paper, or paper towels.

Significantly, the shortage of bathroom supplies at Kingsboro, and at other facilities, did not always appear to be unintentional. Commission staff were told by ward staff at various facilities that toilet paper and paper towels

*South Beach Psychiatric Center, one of the State's newer facilities, has semi-private bathrooms shared by patients sleeping in two or three semi-private bedroom units.

were not provided because a few patients tended to stuff them down toilets. We were also told that soap dispensers had been abandoned as a means of providing sanitary soap to patients because they were too difficult to keep filled.





Bed/Bathing Linens

Maintaining an adequate supply of bed and bathing linens appeared to be a difficult task for all of the nine facilities. Only at one facility (Pilgrim Psychiatric Center) were shortages of linens not observed during the Commission's three-day visit. At four of the facilities these problems were primarily restricted to missing bed linens on certain wards (e.g., bedspreads, pillowcases, etc.). At the other four facilities (Bronx, Manhattan, South Beach, and Kingsboro Psychiatric Centers), however, the

deficiencies were considerably more serious, with many wards lacking sufficient towels and washcloths for patients and many beds on the majority of wards lacking bed linens. Commission staff observed, and ward staff reported at these facilities, the common practice of patients drying themselves with sheets because towels were unavailable.

The Commission's specific observations regarding the availability of linens at the four New York City facilities, detailed below, indicate the severity of these shortages on patients:

South Beach: Towel shortages were reported on all wards and the use of sheets as towels was observed on two wards during the Commission's visits. Bed linen shortages were also noted on five of the six wards visited. Some beds had only one sheet and others lacked pillowcases. The lack of bedspreads was a particular problem, with no bedspreads at all on one ward.

Manhattan: Sufficient washcloths were not available on five of the six wards visited. On one ward there were no towels and patients were using sheets, instead. Many beds on several wards were without pillowcases, and some pillows were less than 1/2" thick.

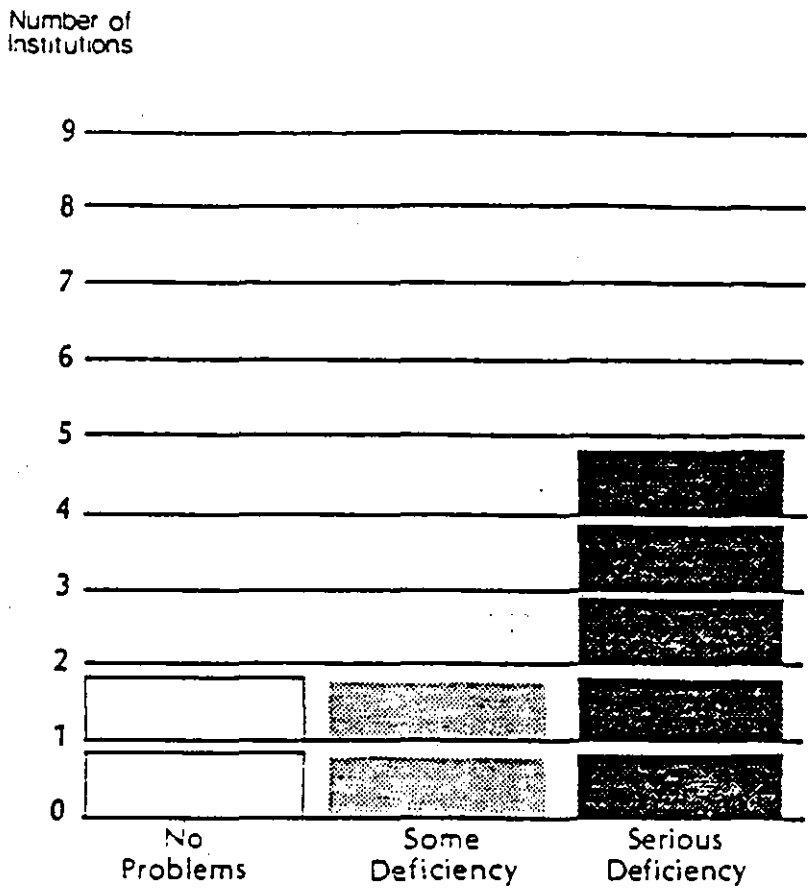
Bronx: Some bed linens on some beds were missing on all wards. Some beds had only one sheet, and on four wards some beds lacked pillows or pillowcases. Shabby, worn bedspreads/ blankets lent a dismal ambiance to dormitories. A towel scarcity was reported by staff and patients. Patients, except on laundry day, often used sheets instead of towels for drying.

Kingsboro: Towels and washcloths were scarce on all six wards. Many patients were observed going without washcloths and using sheets instead of towels to dry themselves after showers.

Like the problems with clothing and personal hygiene supplies, the shortages of bed and bathing linens usually reflected a major breakdown in management. The adequacy and timeliness of laundry services, as well as the facilities' capability to ensure the distribution of linens to the wards, were major factors contributing to the linen shortage. These problems were compounded at several New York City facilities because these facilities did not have their own laundry services and relied instead on the laundry services of other facilities, which were sometimes unreliable. It was not uncommon for one ward to be without towels, while a nearby ward had an ample supply. Commission staff also observed many linen storage areas in disarray, making it difficult for ward staff to keep an accurate inventory of available linen.

Conditions on the Wards

Environmental conditions on the wards were also a major focus of the Commission's review. The review sought to assess the adequacy of basic housekeeping on the wards, as well as the adequacy of routine maintenance of the physical plant of the facilities. Reviewers also looked at the overall attractiveness of the ward environments for patients, noting the state of ward furniture and the presence of curtains or shades on windows, wall decorations, plants, and other features which would contribute to a comfortable environment for patients. As the presentation of the findings of this aspect of the review evidences, the Commission observed striking variations in the environmental conditions of the 54 sampled wards across the nine visited facilities. While at least some wards of each facility were beset with some serious environmental deficiencies which adversely affected patient life, it was equally notable that selective wards or selective areas on wards of eight of the nine facilities also appeared as islands of excellence, demonstrating the potential of State psychiatric centers to provide quality environments for patients.



Clean Living Areas

Basic housekeeping was a serious facilitywide problem on wards of five of the nine facilities. At two other facilities, housekeeping deficiencies were noted in isolated areas. Notably, all the wards visited at two facilities (Binghamton and Rochester) were clean; and at Pilgrim Psychiatric Center, the largest facility in the State serving over 3,000 patients, housekeeping deficiencies were limited to one dining area. All other visited areas of Pilgrim, despite its size and aging physical plant, were clean.

At the five facilities where facilitywide housekeeping problems were noted it was apparent, however, that inattention to basic cleanliness issues had persisted long-term with very dirty floors, substantial litter and dust problems, and several bathrooms smelling of urine and caked with mildew and mold. Buffalo's and South Beach's housekeeping problems were typical of the serious problems noted during the Commission's review. At Buffalo, dayrooms on four wards were very dirty. Urine puddles were noted on dayroom floors of two wards. Other dayrooms were littered with cigarette butts. Dayroom floors on all four wards were badly in need of a thorough cleaning. Toilet and shower areas on all six wards were dirty; cigarette butts littered the floors; cobwebs hung from ceilings; ventilation ducts were filthy; and some shower ceilings were mold-covered.

At South Beach, dayroom floors and curtains were dirty on two wards. All seclusion rooms on the six wards at the facility needed cleaning and four had a strong smell of urine. Some bedrooms on four wards were also generally dirty, with some walls decorated with graffiti. Some bathrooms on four wards were also odorous, dirty, and/or mildewy. In some instances there was urine on the floor.

Without question, however, the housekeeping problems at Bronx and Kingsboro Psychiatric Centers were the most grave. At these facilities conditions bordered on abuse and

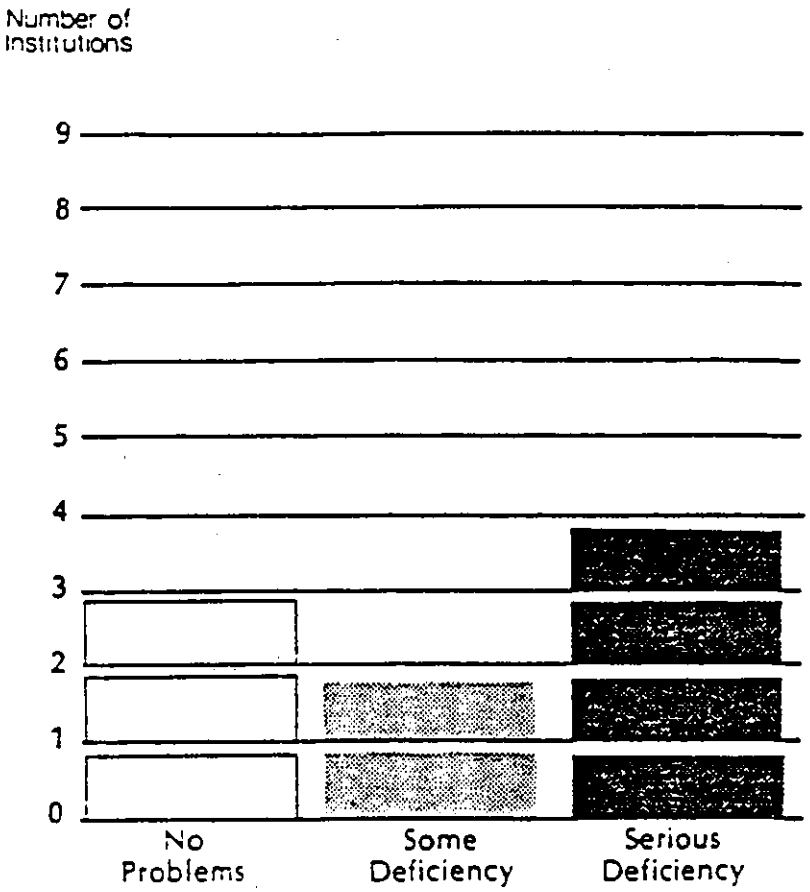
reflected a hardened disregard for the conditions in which patients lived. At Kingsboro day halls on five of six visited wards were extremely dirty, with floors so layered with dirt that the pattern on the lineoleum had been obscured. Bathrooms on four wards were also dirty, with littered floors, stained walls, and unclean sinks and toilets. On all wards at Kingsboro, facility staff complained of inadequate housekeeping services and they were particularly critical of the total absence of housekeeping staff on weekends.

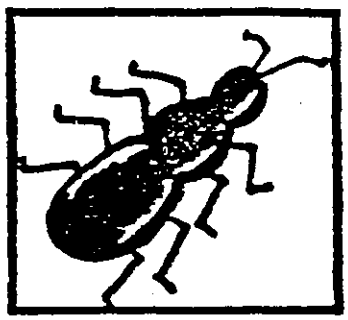
In addition, Commission staff observed drains on porches, where patients congregated at Kingsboro Psychiatric Center, that were clogged with feces and urine resulting in an unbearable stench and an obvious public health hazard. These interconnected drains on a several story building had at one time been used by patients as latrines when it was the ward's policy to lock patient bathrooms at night. This policy had been discontinued at the time of the Commission visits, but the porch drains were not cleaned.

Similar, and on some wards, worse housekeeping practices were noted at Bronx Psychiatric Center. Dayrooms, dormitories, and bathrooms of all six wards were generally dirty. Floors needed mopping and were often littered with cigarette butts and scraps of paper. Shower stalls and benches were mildewed or caked with bits of dried soap. Radiators throughout had been stuffed with paper scraps and

cigarette butts; and wall fans were dirt encrusted. Seclusion rooms at the Bronx were especially filthy, with urine on the floors of some and others reeking of urine. On one ward, Commission staff observed a seclusion room with extremely dirty floors and walls and a strong stench of urine.

Facility staff at many of the nine facilities told the Commission that a shortage of housekeeping staff was the major factor in the serious housekeeping problems that were observed. At some facilities, staff also complained, however, of the inefficient scheduling of housekeeping staff and their poor supervison by facility administrators. Significantly, facility directors' formal written responses to the cleanliness deficiencies usually incorporated both the filling of housekeeping staff items and stricter administrative accountability for housekeeping work plans and for the supervision of housekeeping staff.

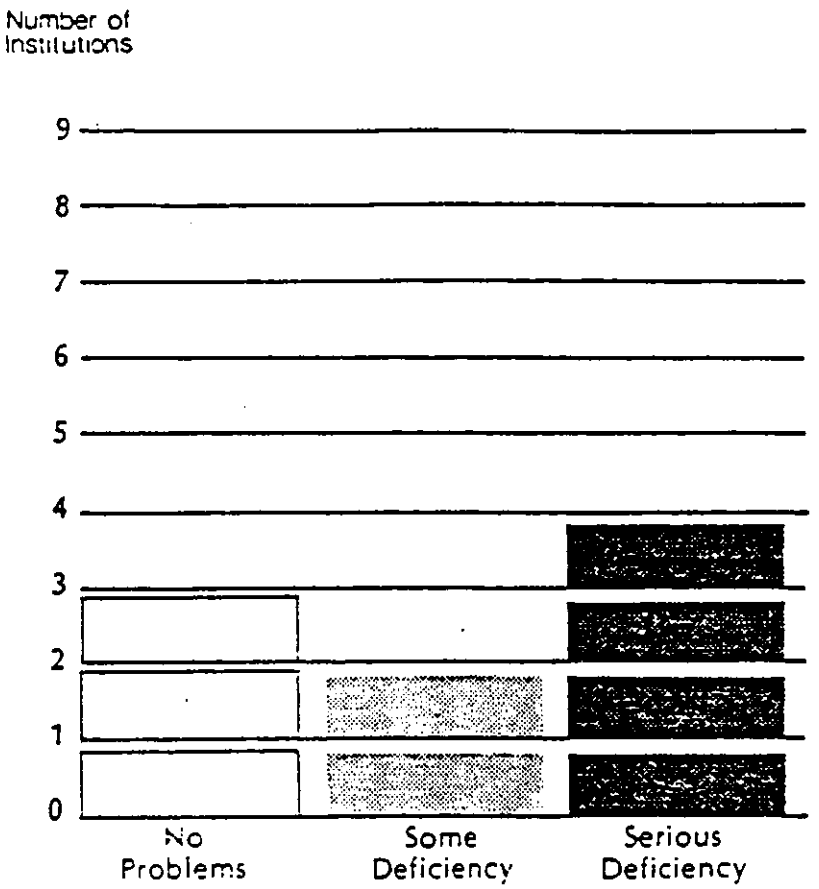




Vermin Infestation

Closely related to the basic cleanliness problems on the wards was the problem with vermin infestation. With the exception of three facilities (Binghamton, Middletown, and Pilgrim) staff and sometimes patients reported problems with vermin on all wards. While at two facilities the problem was limited to roach infestations, at all four New York City

facilities mice and sometimes rats were also a reported problem. At the Bronx Psychiatric Center, one ward was reportedly infested with lice, as well as roaches and mice. At several facilities Commission staff observed roaches, and at one facility (Manhattan) a mouse was observed running across the dining room during the noontime meal.



Walls, Ceilings & Windows

General physical plant deficiencies often compounded problems of basic cleanliness in contributing to poor living conditions for patients. At six of the nine visited facilities walls and ceilings in several areas required maintenance due to water leaks, peeling paint, or general deterioration. Broken windows that had been boarded up and

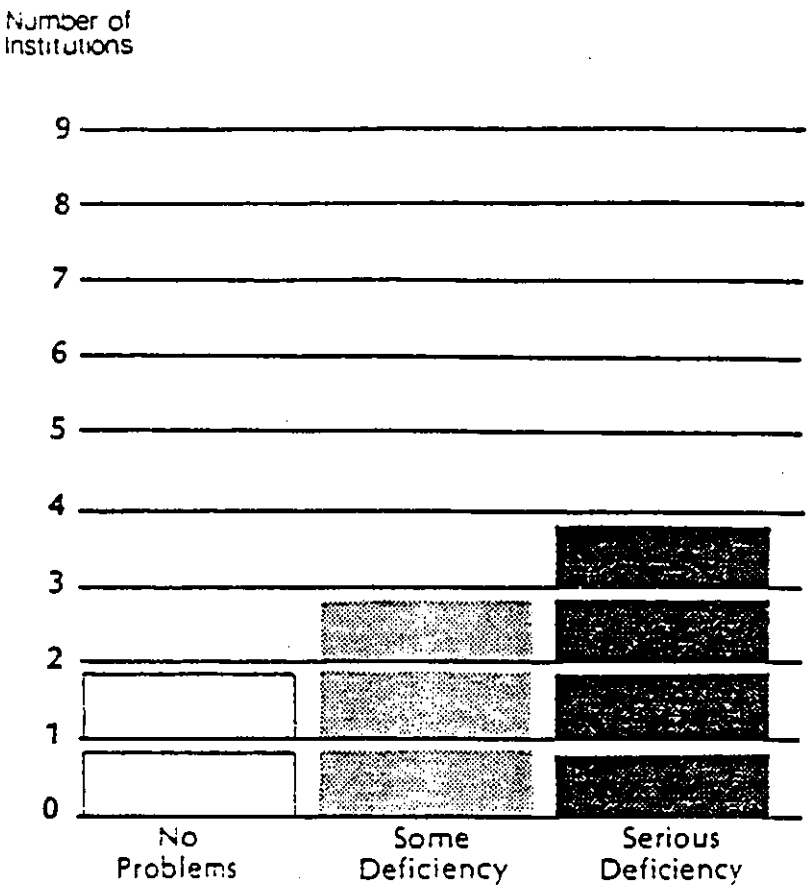
gone unrepaired for some time were also noted at two facilities. In addition, at two facilities, Pilgrim and Buffalo Psychiatric Centers, ceiling repair for leaks or electrical problems had been initiated but not completed, leaving exposed wires, dangling light fixtures, and holes in ceilings for long periods of time.

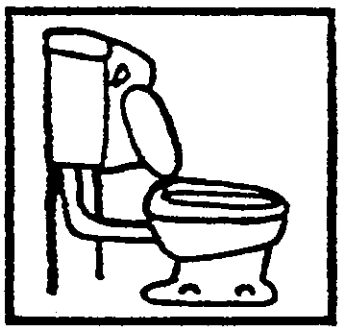
For example, the physical plant at Pilgrim Psychiatric Center, although clean, was decaying throughout. Ceilings were crumbling, leaking, or otherwise showing signs of water damage. Paint was peeling off most wards' walls. Facility staff responded with dismayed acceptance to the Commission's observation of these conditions, as they dutifully used large 10-gallon garbage cans to collect water from ceiling leaks during a rainy day of the Commission's visits.

At South Beach Psychiatric Center, most wards required wall and ceiling maintenance, including painting, replacement of tiles, and repair of holes. One or more windows on the three wards at South Beach were also broken and had been boarded up for some time. Wall and ceiling maintenance was also a serious problem at Bronx Psychiatric Center. Most areas on five of the six wards visited at the Bronx required repainting.

At Kingsboro Psychiatric Center, interior maintenance of walls, ceilings, and windows had been neglected over a long

period of time. Window screens were hanging precariously from many windows; paint on most ceilings and walls was peeling; and crumbling, deteriorated plaster and boarded-up broken windows were common sights. The overall impression of the facility was that of a collection of abandoned buildings.





Plumbing Problems

The most serious physical plant deficiencies observed were often bathroom plumbing problems. At three facilities (Binghamton, Rochester, and Buffalo) these problems usually appeared on only some wards and only resulted in a minor inconvenience to patients who could not use one or two sinks or toilets.

At the remaining four facilities, the plumbing problems we observed were more serious. At Bronx Psychiatric Center for example, all wards visited had at least one plumbing problem, ranging from toilets which would not flush to some sink faucets which were inoperable to plumbing leaks resulting in water on the floors.

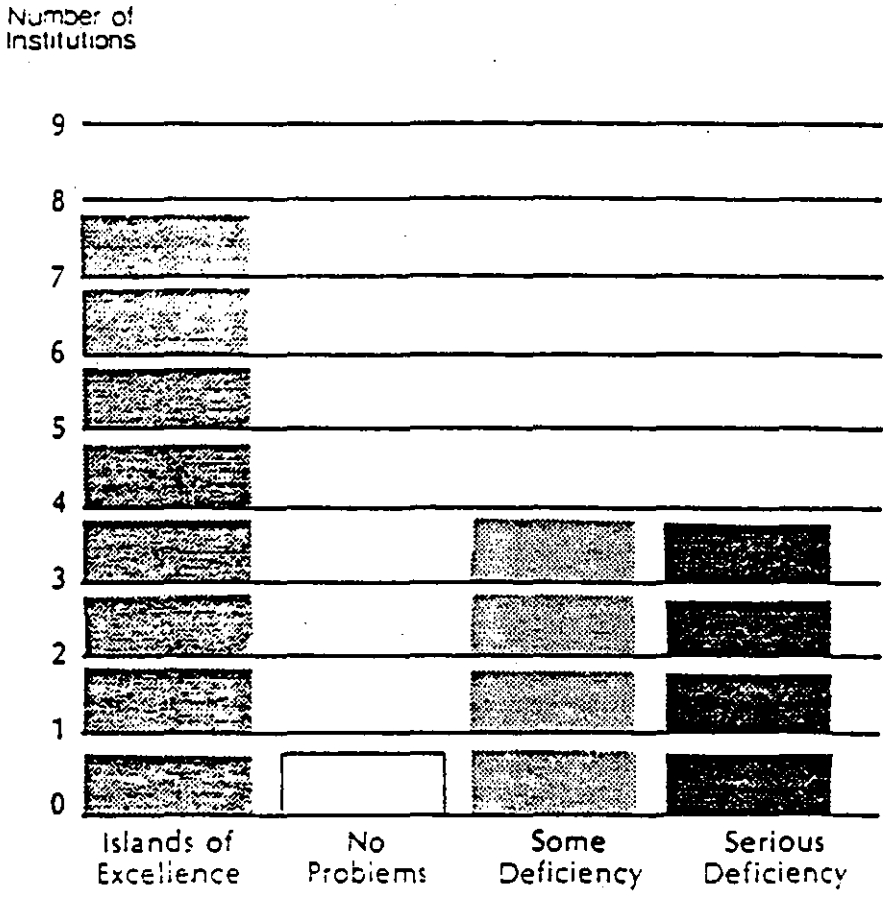
At Pilgrim Psychiatric Center nearly all bathrooms visited had more than one significant plumbing problem. Commission staff observed malfunctioning toilets, inoperable sink faucets and shower controls, sinks which would not drain, and general plumbing leaks on all six wards. In addition, all water fountains on all six wards of Pilgrim were inoperable.

At South Beach Psychiatric Center the serious plumbing problems included some broken showers on five wards, some broken toilets on three wards, and some inoperable faucets and drains on five wards. Repair of plumbing problems also appeared to be a significant problem at South Beach, with individual bathrooms often closed for months at a time.

At Kingsboro Psychiatric Center inoperable plumbing appeared to be the general rule. On five of the six wards visited, sinks did not drain properly; faucets were not in working order (in some instances they couldn't be turned on, in others they ran continuously and could not be turned off); and toilets did not work or leaked when used. In addition,

sinks, toilets, and water fountains had been removed from several wards because they did not work, but the connecting plumbing pipes were left protruding from floors and walls, creating safety hazards for patients.

Like many other problems noted during our review, the physical plant deficiencies, although obviously a resource issue, were also a product of poor management. At a number of facilities, ward staff complained of long delays in the processing of work orders, shoddy repair work, and inferior materials which compounded often routine repair and maintenance work. Notably, at several facilities long pending repair work was done during the three days of the Commission's visit. In one case, a repair and maintenance team virtually followed the Commission staff on their rounds. Ward staff responded appreciatively as their work orders submitted weeks ago finally received attention. It is also significant that at all of the facilities where serious physical plant maintenance issues were noted, the formal responses of facility directors cited the need for capital plant maintenance funds, but also included plans to improve the administrative processing and accountability for work orders.



Attractiveness of Environment

The housekeeping and physical plant problems, together with the frequently observed broken and dirty furniture, contributed to the overall unattractiveness of many of the wards at the nine facilities. Staff efforts to do what was possible to make wards more attractive with personalized touches also varied substantially from ward to ward even within the same facility.

At eight of the nine facilities we observed at least two wards which were barren. On these wards, curtains and shades were often either missing or half-hung and/or shabby. There were few pictures or plants or any other decorations evidencing staff efforts to work with patients to make the ward environment a comfortable one. Dayrooms were often stark, with furniture lined up against the walls, and dormitories were, at best, sterile rows of beds lacking bedspreads. Other dormitories were in a state of disarray with garbage littering bedstands and windowsills and most beds left unmade in a tumble of sheets and dirty clothing.

Significantly, also at eight of the nine facilities, the Commission staff observed at least one patient living area, and often more than one, that was bright, cheerful, and replete with attractive furnishings and decorations. These areas stood as sharp reminders of the potential of the nine centers to provide comfortable settings for patients.

At Binghamton Psychiatric Center, for example, all of the three women's wards visited were well decorated and attractive with pictures and other wall decorations, beds with colorful and attractive bedspreads, and dayrooms with antique-type furniture (i.e., rockers, overstuffed chairs) and many plants. There were handmade afghans on the geriatric wards and patient pictures in hand crocheted frames hung on the walls.

A geriatric ward at Middletown Psychiatric Center was similarly pleasant, bright, and clean. Its dayroom was tastefully decorated and furnished with tables, chairs, bookcases, plants, paintings, and curtains. The room itself was divided into different activity areas which made it appear less institutional. At Rochester Psychiatric Center some wards visited had converted staff offices into rooms equipped with stereo equipment and furnished with couches and chairs, and books and magazines. The many patients in these living areas, which were used as alternatives to larger dayrooms, attested to their popularity.

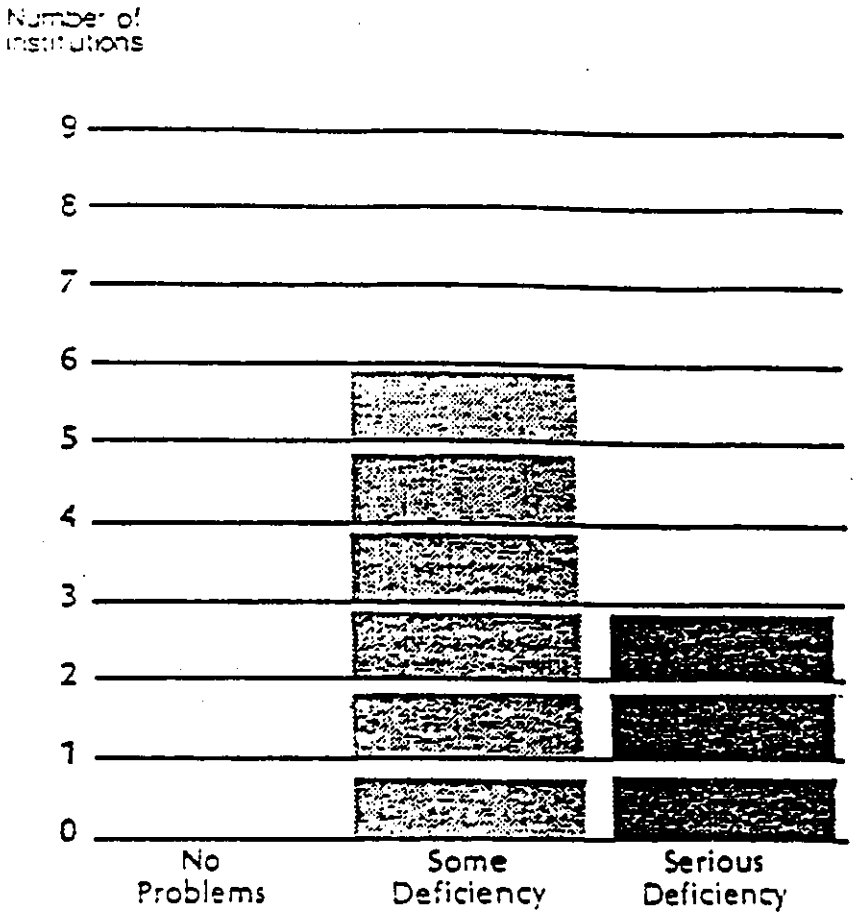
Finally, at Manhattan Psychiatric Center, where most all patient living areas visited had housekeeping deficiencies, one ward, a male acute admissions ward, stood out as being very attractively furnished with many special touches. Here patients enjoyed a spotlessly clean ward with many personalized and interesting decorations. Leisure time equipment, including an exercise bike, was also present for patients. Significantly, this ward also stood apart from other wards at Manhattan in the readily observable staff and patient efforts to care for the ward and its unusual furnishings and equipment.

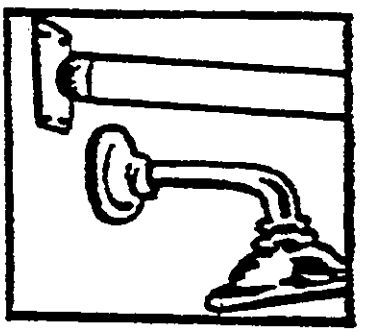
Although difficult to document, it was also clear to Commission staff that patients who enjoyed attractive, well decorated, and comfortable rooms responded to the positive aspects of their environments. Whereas ward staff at some facilities told the Commission staff visiting the facilities that it was impossible to keep ward furniture clean or unscarred by cigarette burns, or that wall decorations were lacking because they were constantly defaced or torn down by patients, we could not help but observe that there was little destruction or disregard for ward furnishings in the well-decorated areas that served patients with similar levels of disabilities. It appeared that when patients were provided with a well-maintained and attractive environment, they readily accepted the responsibility to preserve it.

Patient Health and Safety

The Commission's review also addressed the fire safety features of the wards, obvious suicide hazards, and the availability of emergency medical equipment.

The adequacy of emergency medical care and the presence of safety and suicide hazards have been longstanding, and often cited, concerns of the Commission and its Mental Hygiene Medical Review Board which reviews unusual deaths of patients in State mental hygiene facilities. The Commission has been frequently informed by relatives of serious injuries caused by slippery floors, fall hazards, and exposed radiators and hot water pipes. In addition, investigations of unusual deaths have surfaced numerous instances where life-saving emergency medical equipment was either not promptly available or, when available, was not operable. There have also been incidents of patient suicides by hanging from non-breakaway shower bars or other overhead unenclosed pipes in patient areas.





Suicide & Safety Hazards

Potential suicide and safety hazards were observed at all nine of the visited facilities. Common problems were non-breakaway bars in shower and toilet stalls and exposed overhead sprinkler pipes which presented suicide hazards to patients. Notably, on some wards of some facilities, including Binghamton and Manhattan Psychiatric Centers, breakaway bars had been installed and sprinkler pipes had been enclosed as a part of OMH's recently implemented capital improvement project to rid facilities of suicide hazards.

Fire safety problems were also noted at five facilities (Rochester, Bronx, Buffalo, South Beach, and Kingsboro Psychiatric Centers). The most typical fire safety problem stemmed from overcrowding of beds in dormitories which resulted in the blocking of dormitory doors. Other problems included inadequate means of egress in case of fire, the lack of fire extinguishers, and fire extinguishers which had not been recently inspected.

At three facilities safety and suicide hazards were more serious. At Kingsboro Psychiatric Center the physical plant deficiencies were so serious as to present dangerous safety hazards to all patients. All patients were exposed to crumbling walls, protruding plumbing pipes from fixtures which had been removed, and very slippery floors caused by plumbing and ceiling leaks. At Kingsboro, Commission staff also noted many unshielded radiators and very hot uninsulated hot water pipes which were easily accessible to patients and which could cause serious burns.*

*In November 1983, the Commission received a complaint from a relative of a patient at Kingsboro who had received serious facial burns from falling on these pipes. Although the patient recovered from her burns, her face remains permanently scarred.

At two other facilities, suicide hazards were noted in patient seclusion rooms.* At South Beach Psychiatric Center several seclusion rooms presented hazards including an exposed light fixture, sharp-edged bed frames, and loose sheets. In one of Buffalo Psychiatric Center's seclusion rooms, a radiator was shielded with a sharp metal edged cover, curtain rod hooks which could hold substantial weight were securely in place, and the hardware of an inoperable dead bolt lock was left secured on the inside of the door.

*Extremely agitated and/or suicidal patients at State psychiatric centers are sometimes confined to seclusion rooms as a treatment intervention to calm the patient and/or to preclude patient attempts at self-injury.

Emergency Medical Care Equipment

A major concern of the Commission's Mental Hygiene Medical Review Board which reviews unusual deaths of patients in mental hygiene facilities has been the availability, prompt accessibility, and working condition of emergency medical care equipment. In the course of this review, the Commission sought to determine if well stocked first aid kits were available on the wards and if more sophisticated emergency medical equipment was promptly accessible.

Only at three facilities, South Beach, Rochester, and Middletown Psychiatric Centers, were no problems observed in this area. At three centers, Pilgrim, Manhattan, and Bronx Psychiatric Centers, available supplies in wards' first aid kits varied substantially, and staff generally were confused as to the facility's policy for what constituted required first aid supplies. On some wards, ward staff could not indicate where emergency medical equipment was stored, and on one ward visited, when staff were asked to bring the emergency medical cart to the Commission reviewer, ward staff brought a blood pressure cuff and stethoscope. Ward staff at another facility reported that there is no routine inspection of emergency medical equipment.

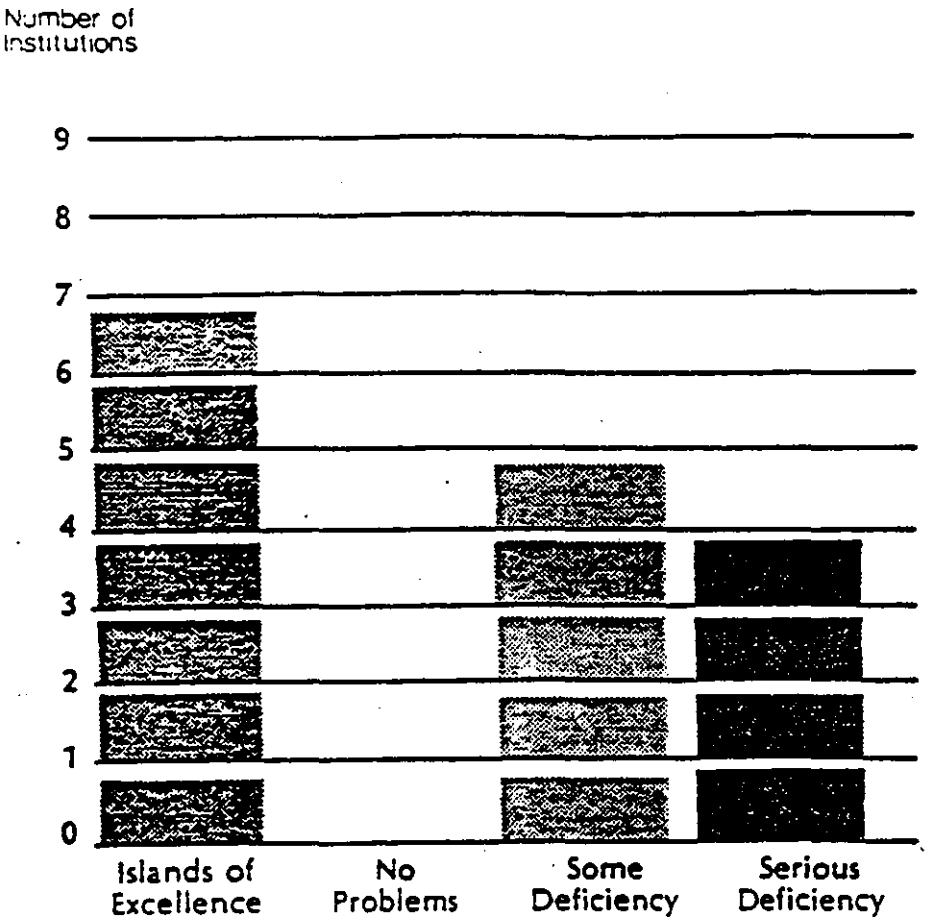
The prompt accessibility of emergency medical carts also varied substantially among facilities and among wards within facilities. For example, at four of the facilities each visited ward had an emergency medical cart in addition to

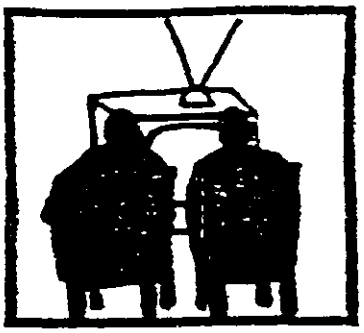
first aid supplies. At Binghamton Psychiatric Center, on the other hand, two wards shared the available emergency medical cart with four other wards, and at Kingsboro Psychiatric Center emergency medical carts were generally shared among four wards. At Manhattan Psychiatric Center, although each ward had first aid supplies, including an emergency drug box and resuscitation equipment, other necessary emergency medical equipment was located in the basement emergency room of one of the two high-rise patient buildings. Although the facility safety department had procedures designed to move patients promptly to this equipment (i.e., central hold on elevators, etc.), the Commission questioned the timely accessibility of this equipment for patients on the upper floors of the building where the emergency room is located and for patients in the other patient building.

Based on these findings, it was apparent that the issue of what constitutes appropriate and accessible emergency medical equipment remains an unclear and debated one in State psychiatric facilities. Clearly, some facilities have implemented fairly strict standards in this area, but others, in the absence of an explicit OMH policy, have set standards considerably lower. The findings similarly indicated the great disparity in ward staff awareness of the availability and location of emergency medical care equipment, whatever the facility standard.

Quality of Patient Life

All of the issues addressed on the previous pages have a primary and concrete relationship to the quality of patient life at State psychiatric centers. While these issues, like clothing, grooming and bathroom supplies, and good housekeeping and physical plant maintenance are certainly the most tangible and objectively measurable, other less tangible issues have an equally fundamental impact on the quality of life for patients. Having something to do; having some personal privacy; being able to ensure protection of personal belongings; and knowing the day, date, and time are among these other less tangible issues. In the course of the Commission's review, these issues were also examined, often with despairing findings.





Patient Idleness

Perhaps the issue which most pervasively affected the quality of life at the nine visited facilities was patient idleness. At all facilities there was little structured activity for most patients on the wards during their waking hours. Sitting in dayrooms, pacing the floors, or staring at television sets were the primary daily activities for many patients. At the same time, we also observed examples of exemplary staff efforts to initiate patient activities on

some wards at seven of the facilities. Significantly, these ward activities, with rare exceptions, were designed and conducted by ward staff. Despite cutbacks in recreational staff during the 1984 staff layoffs, these facilities, at least on selective wards, had done "more with less."

For example, at Binghamton Psychiatric Center, some wards offered patients a work for pay program, and two wards provided a centralized activity area where patients worked on arts and crafts and were able to sell, swap, and keep their projects.

At Manhattan Psychiatric Center, we observed one ward where patients woke to piped-in music and began their day with a morning exercise program designed by ward staff. Some other special activities observed during the three days at Manhattan included a coed dance and social, a movie, and a nature project with animals brought to the ward from the Bronx Zoo.

One ward of South Beach Psychiatric Center offered a very impressive token incentive program for patients to improve their daily living skills. And, a ward of Rochester Psychiatric Center had converted a dining room area to a coffee shop, which served both as a social area for patients and staff and as a setting for occupational therapy.

But as a general rule, patient inactivity was the norm. Although many wards had a supply of leisure time equipment

and materials, these were usually locked up and inaccessible to patients. On most wards we observed minimal staff efforts to involve patients in meaningful activities. Across the nine facilities, many of the patients interviewed complained of inactivity. A comment from a patient at South Beach Psychiatric Center is demonstrative, "All there is to do here is read and I don't know how."

At Rochester Psychiatric Center little evidence was seen of active therapy or programming being carried out for the majority of patients on five of the six visited wards over the three-day period. Similarly, at Pilgrim and Bronx Psychiatric Centers, few organized activities were observed on the wards during the three-day period, and many patients spent portions of the day sleeping on floors and dayroom furniture. During the more than 60 hours Commission staff spent at Kingsboro Psychiatric Center, only one patient activity was observed and on none of the wards did we note any patients using leisure time materials, like playing cards, games, books, magazines, etc. For the most part, patients were sitting idly or pacing around the wards.

Short staffing, coupled with the severe overcrowding at many facilities, contributed significantly to the problem of patient idleness. Staffing levels of only two to three staff persons for wards of 30-35 patients left little staff time to go beyond basic custodial care to provide activities for

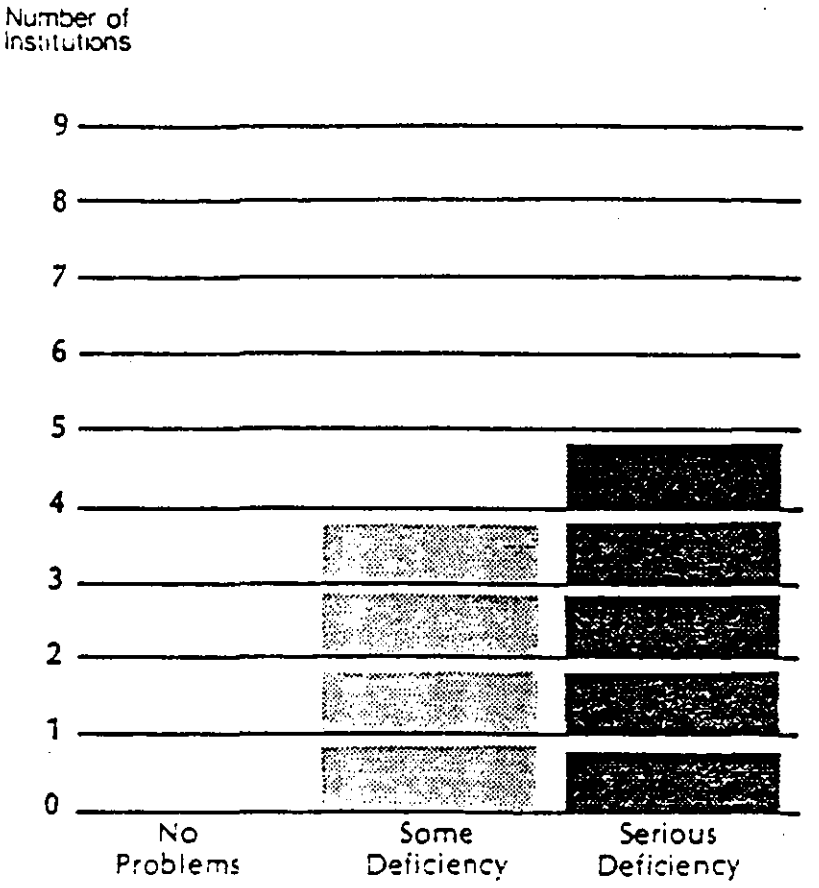
patients. In addition, overcrowding of wards left many staff discouraged and reluctant to pick up the tasks of their laid-off recreational therapist colleagues.

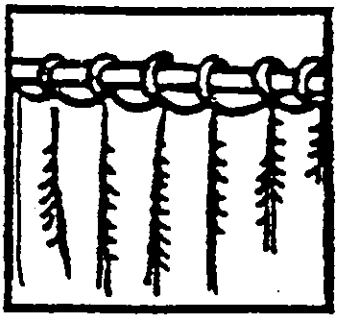
It is also significant that, unlike New York State developmental centers which provide residential care for persons with developmental disabilities,* State psychiatric centers have no required level of patient programming or rehabilitative services. Whereas State Mental Hygiene regulations require State developmental centers to provide at least six hours of programming, there is no OMH or JCAH standard which explicitly mandates programming requirements for State psychiatric centers. As a result, there is no minimal threshold for ward staffing to ensure meaningful activities for patients in State psychiatric centers and the common circumstance of virtually no patient activity on the wards is tolerated.

Another factor which has contributed to patient idleness is the unwritten proscription against patient participation in the daily maintenance of their ward environment. Overreaction to court decisions forbidding the involuntary servitude of patients in public institutions has resulted in

*Developmental disabilities include mental retardation, epilepsy, autism, neurological impairments, learning disabilities, and other serious functional disabilities with an onset before the age of 18.

most facilities exempting patients from any responsibility for housekeeping and other routine activities of daily living while they are on the wards. Although more recent court decisions have clearly indicated that these activities are permissible and State Mental Hygiene regulations indicate that these activities are desirable if they become components of the patient's treatment plan and promote his/her readiness for independent living upon discharge, few patients' programs include these activities. As a consequence, patients of New York State psychiatric centers, like those of many other states, spend their days on short-staffed wards with virtually nothing to do, and their potential contributions to better ward environments are sorely missed.





Patient Privacy

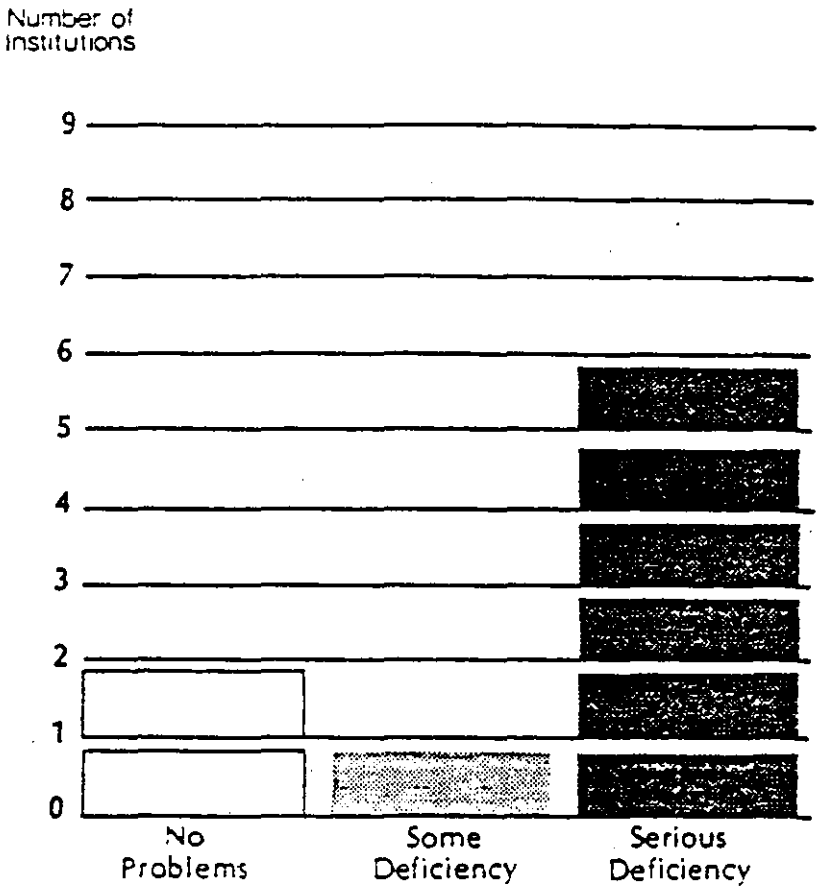
Patient privacy was also seriously compromised at six of the nine visited facilities by severe overcrowding. Spacing of beds in dorms left patients with virtually no privacy at night. Bathroom privacy at four facilities (Binghamton, Manhattan, Bronx, and Kingsboro) was also lacking with several or many toilet and shower stalls without doors or curtains. Also, at one facility, Rochester Psychiatric Center, patients were observed on some wards being showered

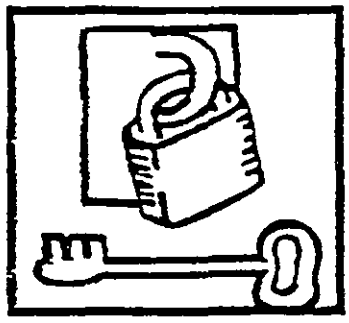
in groups and left to stand for periods of 5 to 15 minutes undressed with no privacy.

In addition, there was an absence of privacy to varying degrees in visiting relatives or friends and in making telephone calls at almost all facilities. Many facilities did not have visitors rooms on the wards at all, and none of the nine facilities made a consistent effort to provide separate and attractive visitors space for patients. Commission staff observed many visitors rooms that were cramped, dirty, and extremely unattractive. Those wards with attractive, comfortable visiting rooms, like those observed on certain Manhattan and South Beach Psychiatric Centers' wards, clearly appeared to be the exception, not the rule.

Similarly, access to a telephone for private calls was significantly restricted at eight of the nine facilities. Only at one facility, Rochester, were there few limitations to the free and open access to telephones for patients on the wards. Depending on the ward, patients at Rochester Psychiatric Center could ask to use a telephone in a staff office or a telephone was made available at designated times of the day. At these times, a telephone would be brought into a room and plugged into the wall jack. Staff even assisted patients with making calls, if such help was needed.

At other facilities patients had access to a pay phone only during certain hours of the day, and there was no privacy as several patients (with an accompanying staff person) stood in line behind the caller awaiting their turn to make a call.

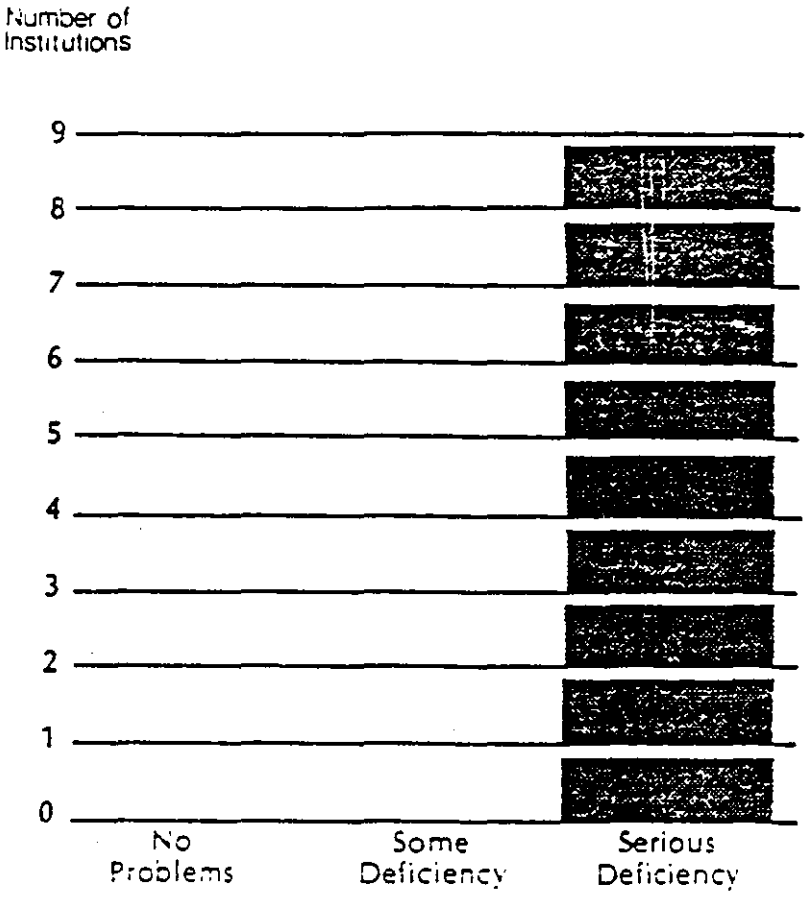


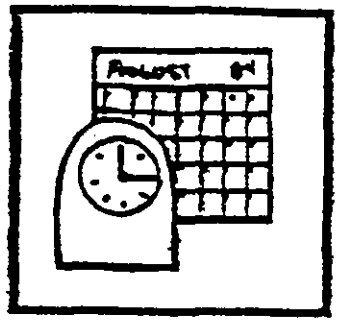


Access/ Protection of Belongings

Access to and protection of patient belongings was also a serious systemic problem. At six of the facilities staff and patients alike reported a significant theft problem, especially for money and underwear. Most patients' wardrobes at all facilities were unlocked and/or unlockable. At three facilities, Manhattan, Bronx, and Kingsboro Psychiatric Centers, this problem was so significant that patients were discouraged from keeping any personal belongings, including

clothing, on the wards. At the two other facilities, security of patient belongings had been addressed primarily by locking dormitory areas early in the morning when patients left for breakfast, and many patients complained about their limited access to their belongings. Although patients at these facilities could theoretically reenter the dormitories during the day with the assistance of a staff member, the many patients observed carrying their belongings, sometimes in several bags, betrayed the impractical implementation of this policy on the short-staffed wards.





Basic Living Amenities

At all nine visited facilities many of the basic amenities of daily living that we all count on were absent--clocks, calendars, posted schedules, free access to drinking water. At five facilities there were no posted calendars in patient areas, and it was rare to find a clock in the sleeping areas of any of the facilities. Program schedules listing patient activities were either absent or inaccurate at seven of the nine facilities. Meal menus were

also not posted in patients areas on most wards of seven facilities. Even access to drinking water was difficult on some wards of several facilities because water fountains were inoperable and there were no paper cups in bathrooms.

Although these issues pale in comparison to some of the more basic deficiencies in patient living conditions noted during the Commission's review, they nonetheless impact on patients who could easily lose track of days, dates, and time in an institutional setting, or whose illness often caused sleepless nights with no clock to check the passing of time. In addition, the prevailing inactivity elevated the importance of advanced notice of the few scheduled activities or the noontime meal. Finally, most patients receive medications which have a common side effect of an exceedingly dry mouth, but at two facilities it was not even easy to get a drink of water.

Chapter III
Conclusion and Recommendations

As the Commission's findings indicate, the quality of the basic living conditions at the nine facilities varied tremendously. More importantly, the Commission's review revealed that, for the most part, the variance was not always above a minimally acceptable standard of care, but sometimes reflected a level of living conditions for patients significantly below standards articulated by state and federal courts. While the Commission encountered islands of quality care for patients, other conditions witnessed by the Commission--including severe overcrowding; serious neglect of basic cleanliness; inadequate clothing; lack of privacy in sleeping, bathing, and toileting; absence of personal hygiene and grooming supplies; restricted access to drinking water and personal belongings; and the endless hours of boredom--would not meet standards which courts have mandated for state and federal prisons. In addition to not meeting court-mandated standards for incarcerated persons, these conditions fundamentally denied the human dignity of patients.

Several conclusions concerning the factors influencing the varied and egregious conditions witnessed by the Commission can be drawn. The most obvious relate to

overcrowding, the sufficiency of resources, and the adequacy of management. To a greater or lesser extent, all of these factors are intertwined in influencing the conditions we observed.

Unlike psychiatric institutions in the private and municipal sectors, which have established limitations on bed capacity, the State psychiatric centers have no such maximum, and as the provider of last resort, the State system faces essentially limitless demands for services. As non-State facilities send their excess patients to State facilities, occupancy goals--used in projecting and budgeting staffing and other resources for State facilities--are frequently significantly exceeded without adequate provision for commensurate increases in resources. The consequences of this overcrowding were plainly evident in the Commission's review.

Overcrowding deprived patients of even minimal privacy at some facilities. It strained limited ward staff's ability to care for patients and manage resources effectively as it crowded too many patients in small spaces making everything from rudimentary housekeeping to attending to patients as individuals more difficult. On some wards, overcrowding also led to inadequate storage space for patients' belongings, while on others beds blocked exit doors creating fire safety hazards.

The responses of the facility directors, as well as the Commission's observations, also indicated that sufficiency of fiscal resources was a factor in several of the more systemic deficiencies. Clearly, long-term neglect of physical plant maintenance, particularly at Kingsboro and Pilgrim Psychiatric Centers, was a problem of insufficient capital funds for maintaining the aging buildings on these campuses. Overcrowding also derived, in part, from staffing level cutbacks, which left facility directors in the difficult position of deciding between inadequately staffed less crowded wards or overcrowded wards which could be staffed at a more adequate level. Similarly, several facility directors indicated that housekeeping and clothing problems, as well as limited ward activities for patients, were partially attributable to the loss of housekeeping, clothing clerk, and recreational therapist personnel.

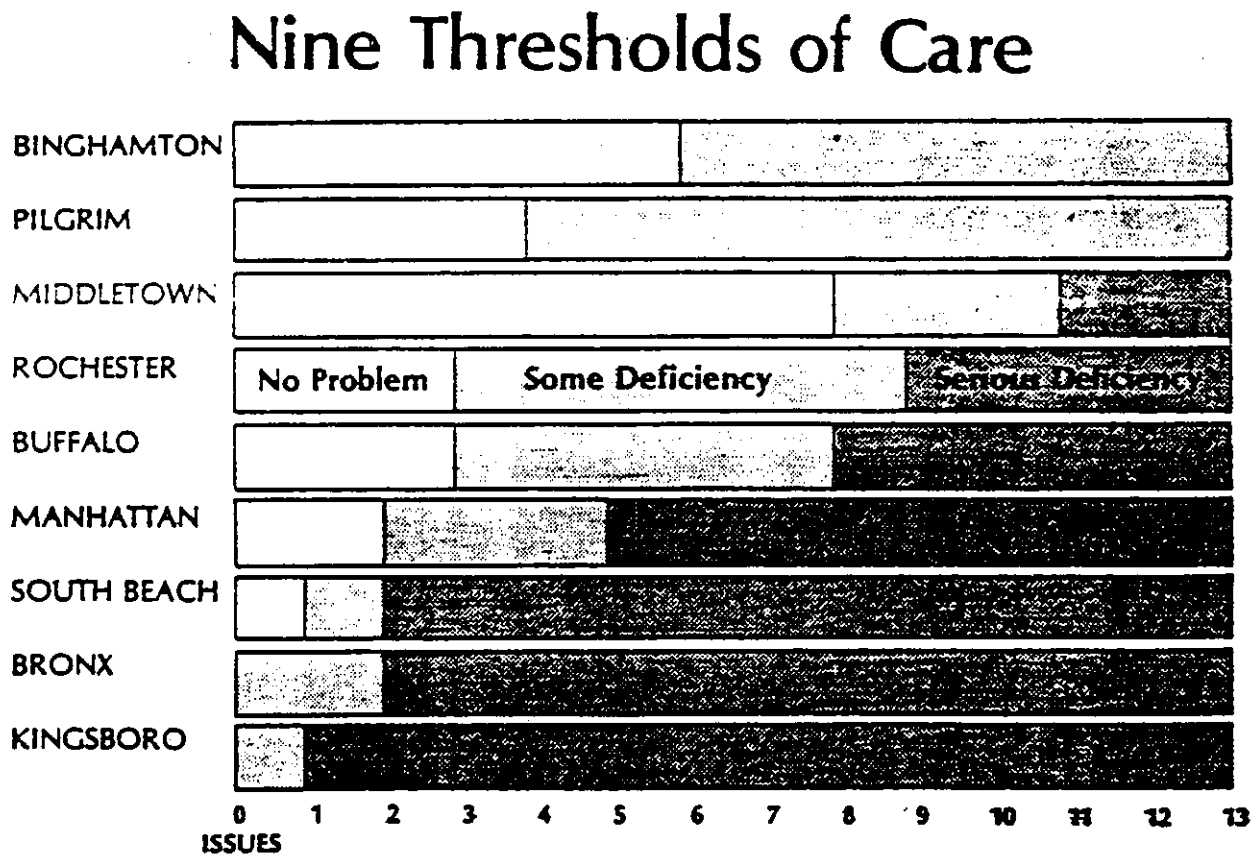
In many instances, however, the deficiencies noted were not primarily the result of insufficient resources or overcrowded wards, but the result of inadequate management systems. This accountability of management for many of the deficiencies was acknowledged in most of the facility directors' responses which referenced new administrative procedures for distributing clothing, grooming, and bathroom supplies; for scheduling and supervising housekeeping and maintenance staff; and for processing work order requests.

In other instances, the Commission was impressed with reports of directors that significant problems had been addressed, primarily using existing resources, within six weeks of our visits. These reported improvements included the cleaning of some wards with serious housekeeping deficiencies; the repair of inoperable bathroom plumbing at four facilities; the removal of prominent safety hazards from seclusion rooms at one facility; and the institution of new contracts and/or more frequent exterminations for vermin control at three facilities. Even on the issue of overcrowding, administrative initiatives were detailed by three facilities. Buffalo Psychiatric Center reported that some patients would be transferred to a less crowded facility. Middletown Psychiatric Center had initiated the movement of some patients from overcrowded wards to less crowded wards. And, Rochester Psychiatric Center reported that a new ward would open in November to alleviate overcrowding.

It is also important to note that the average annual cost of care at the nine facilities exceeds $41,000 per patient. While this sum is reflective of the high cost of staffing State psychiatric centers 24 hours a day and the concomitant expenses for physical plant maintenance and utilities of the many old buildings on the facilities' campuses, it remains fundamental that, within these resources, meeting patients' basic living needs for safe and clean environments and for clothing, personal hygiene, and

bathroom supplies must be the priority of facility managers. The findings of the Commission's review clearly evidenced that this was not uniformly the case. It appeared rather that management inattention to certain basic issues, such as ensuring that patients had underwear, toothbrushes, toilet paper, and even minimally clean living areas had persisted long-term at a number of facilities. The fact that the conditions found by the Commission were allowed to persist despite the ongoing monitoring activities of the Office of Mental Health's central and regional offices further underscored Commission concerns about the system's ability to manage its operations.

As illustrated in the chart below, this review revealed at least nine different thresholds of acceptable living conditions in the nine facilities reviewed. In the absence of a uniform standard of basic living conditions, where facilities drew the line on patient living conditions varied. At Pilgrim Psychiatric Center, for example, where patients were well clothed and had personal hygiene supplies



and most patient areas were clean, most bathrooms suffered significant plumbing problems; patients had limited access to drinking water due to inoperable water fountains; and staff hardly questioned the routine use of ten-gallon garbage cans to collect water from ceiling leaks. At Buffalo Psychiatric Center, patients were also well clothed; bathrooms were generally well stocked; and most bathroom plumbing was operable; but many areas of the facility evidenced long-term serious housekeeping problems and most of the patients interviewed did not have toothbrushes. At Manhattan Psychiatric Center, the standard for acceptable conditions was still different. Here, all bathrooms were operable and well stocked with supplies, but many patients lacked adequate clothing, including clean underwear, and personal hygiene supplies were a luxury shared by only a few of the interviewed patients.

Of great concern to the Commission is that each facility seems free to establish its own threshold of acceptable living conditions. While it is imperative that the highest priority be assigned to eradicating the conditions found during the Commission's review, it is not the conditions alone which warrant attention but the management priorities that allow them to exist. Although questions concerning the adequacy of current resource levels and management systems

must be confronted, such problems cannot be fruitfully resolved until there is an unvarying expectation that the basic human needs of patients are met. It is also clear, given the current state of conditions, that these priorities must be explicitly articulated as a foundation of a mission statement for the Office of Mental Health.

In articulating this mission statement, it is critical that the potential for patients to participate in therapeutic work activities be reexamined on a systemwide basis. Unduly restrictive notions about the proper responsibility of capable patients to attend to their own basic housekeeping needs has eliminated much possibility of patients helping to maintain their living environment. As a result, the quality of life has suffered as pervasive idleness stretches into endless hours of boredom for patients, while their living areas often remain in shambles. The Commission believes it is essential that concerted efforts be made to provide patients with a sense of belonging, participation, and responsibility. There is an absolute need to find constructive activity, consistent with targeted treatment plans, for patients to occupy themselves for most of their waking hours. Needless to say, care must be taken to ensure that such activities do not cross the line between permissive housekeeping and therapeutic work and impermissible institutional maintenance labor.

In developing this statement for State psychiatric centers, the Office of Mental Health would also be well advised to examine the OMRDD system and the impact of requiring "active treatment" on the overall quality of care of residents of developmental centers. It is the Commission's view that the articulation of clear goals, such as specific time requirements for the provision of active programming each day, has facilitated greater success in improving the quality of life for residents. Such goals provide a framework for developing rational staffing requirements and for measuring success or failure, however imperfectly. No such goals currently exist for the mental health system, leaving facilities and their patients vulnerable to the vagaries of the budget-making process and to the varying expectations of performance by diverse constituencies and administrations.

RECOMMENDATIONS

Based on these conclusions, the Commission offers the following recommendations to assist the Office of Mental Health in upgrading the quality of living conditions for patients.

A. Overall Recommendations

1. The Office of Mental Health should, as a matter of high priority, develop a clear and concise mission statement outlining minimum expectations of standards of care that all State psychiatric centers will achieve and maintain. This statement should specifically address the responsibility of these facilities to meet the basic human needs of patients, as well as to provide them with a minimum number of hours of constructive program or activity each day. Each facility should be annually evaluated by the Office of Mental Health against these standards of care and senior managers held accountable for their performance in these areas. Preferably, such evaluations ought to occur on an unannounced basis.

2. The Office of Mental Health should develop, on a priority basis, a policy that requires facilities to develop therapeutic treatment plans for patients which include therapeutic work activity addressing their needs to develop or maintain personal and self-care skills. Such plans may require that patients be given responsibility for housekeeping tasks in their living areas.

3. Every State psychiatric center should be surveyed to identify deficiencies in the physical plant that directly impact upon living conditions for patients. An inventory of repairs, maintenance and capital projects should be developed, prioritized and scheduled. In this process, consideration should be given to temporarily regionalizing maintenance staff to address the most critical problem areas in a timely fashion.

4. The Office of Mental Health should review the impact of reductions in work force upon facility operations which directly impact the quality of life for patients (e.g., food service workers, laundry clerks, recreation therapists, etc.) and, where necessary, request funds to operate at a level that meets the minimum standards of care identified in Recommendation No. 1.

5. Facility directors, deputy directors for institutional administration, and other senior managers who have demonstrated skill in meeting and exceeding acceptable standards of care should be used as resources throughout the system in an effort to upgrade performance in vital areas affecting day-to-day living in psychiatric centers.

6. The Mental Hygiene Law should be amended to add a bill of rights for patients who reside in institutional settings, along the lines of the recently enacted bill of rights for the mentally retarded and developmentally disabled residents of community residential facilities (MHL §41.41). The law should provide that such a bill of rights be posted prominently on every ward of every facility and that the poster contains information on how to contact the facility Board of Visitors, the Mental Health Information Service and the Commission on Quality of Care if a patient believes his or her rights are being violated.

B. Overcrowding

To assist State psychiatric centers in reducing the level of overcrowding on their wards:

1. A high priority should be given to developing additional community residence beds in every catchment area of the State.

2. The Office of Mental Health should seek to establish domiciliary care facilities in each region of the State to provide housing and aftercare services to patients who are ready for discharge from psychiatric centers but for whom

there are inadequate resources in the community. Suitable vacant buildings on the grounds of State psychiatric center campuses are an option that should be explored for this purpose, consistent with the model developed at Creedmoor Psychiatric Center.

3. The Office of Mental Health should seek to develop additional crisis residences to assist each psychiatric center to deflect potential admissions that do not necessarily require acute hospitalization.

4. Realistic program occupancy goals should be established for each psychiatric center, consistent with the resources available, to provide adequate patient care. For those centers that are currently above these occupancy goals, specific plans should be developed to reduce and eventually eliminate the overcrowding. One option that should be considered in the process is the transfer of consenting patients who do not have strong ties to the community to other facilities in the State providing equal or better conditions.

5. The Office of Mental Health should consider accelerated development of day hospital programs to reduce the pressures for inpatient psychiatric care.

C. Internal Monitoring

1. The Office of Mental Health should require every psychiatric center to create and utilize an internal review mechanism to periodically evaluate the facility against accreditation standards. Such evaluations ought to be conducted sufficiently frequently to ensure that standards are being continually maintained. Reports of these surveys should be made available to the facility director, the deputy director clinical, unit chiefs, and ward level staff, as well as the Regional Office and boards of visitors. The facility director should be held accountable for the implementation of any corrective actions identified as being necessary in these surveys.

2. Every psychiatric center should clearly establish personal accountability at the ward level and at the unit level for living conditions which exist. There should be a specified individual on each shift who is personally accountable for ensuring that living conditions comply with the minimum standards that are established.

3. To facilitate clearer communication and priority setting with respect to housekeeping and maintenance at facilities, each facility should establish periodic meetings of clinical staff and maintenance/support staff.

D. Miscellaneous

The Office of Mental Health should arrange for representatives from several facilities to meet with purchasing agents at the Office of General Services to make clear the special needs of psychiatric centers for furniture and patient clothing. The need for such communication is particularly acute with respect for furnishing requirements for secure units and other units that house aggressive, acting out patients.

Appendix A

NEW YORK STATE
OFFICE OF MENTAL HEALTH 44 Holland Avenue, Albany, New York 12229

STEVEN E. KATZ, M.D., Commissioner

Response by The New York State Office of Mental Health to the Draft Report Prepared by The Commission on Quality of Care for the Mentally Disabled on the "Quality of Life in Nine New York State Psychiatric Centers"

December, 1984

THE OFFICE OF MENTAL HEALTH RESPONSE TO THE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED'S REPORT ON THE QUALITY OF LIFE AT NINE NEW YORK STATE PSYCHIATRIC CENTERS

Every patient on every ward in every psychiatric center is entitled to a clean environment, personal hygiene care, appropriate clothing, decent food and basic medical care in addition to psychiatric treatment. The Commission on Quality of Care report identifies on certain wards unacceptable living conditions. The most serious deficiencies were concentrated on 30 wards at 5 of OMH's 33 facilities.

The Office of Mental Health has moved to vigorously correct deficiencies and establish management systems which will sustain improvements. Our efforts focused on five major actions:

(1) CORRECTION OF DEFICIENCIES--Of the 1,377 deficiencies cited, 862 (63%) have been corrected, and 438 (32%) are in the process of being corrected. Of the balance of these findings (5%), OMH disagrees that action is required in 3%, and requires additional resources for compliance in 2%. We urge the Commission staff to revisit these facilities to observe first-hand the significant improvements since May.

(2) MANAGERIAL CHANGES--When it is necessary to make staff changes, the Office of Mental Health has and will continue to make those changes. This applies to staff at all levels in the facilities, Regional, and Central Office. New Executive Directors have been appointed at three of the hospitals cited as experiencing the most serious problems (Kingsboro, Bronx, Buffalo). In addition, other executive staff were replaced.

(3) NEW PROCEDURE AND SYSTEMS--OMH will institute by December 31, 1984 the following standard procedures:

(a) The environmental and personal care reviews now done by many centers will be standardized at all centers to provide for uniform reviews of basic living conditions.

(b) Each Regional Office will develop a schedule for unannounced site visits to review the conditions and circumstances in each psychiatric center. Central Office follow-up will occur with Regional Offices as appropriate.

(c) A special team of Central Office staff has reviewed with the Regional Offices the facilities cited as having the most serious problems. Technical assistance has and is continuing to be provided with corrective actions made as required.

(4) IMPROVED DIRECT CARE AND SUPPORT STAFFING LEVELS--Two weeks prior to the May CQC site visits, facilities were notified of the 1984-85 resource allocation. Therefore, the additional direct care and support staff allocated to OMH for 1984-85 had not been hired at the time of the visits. These additional staff have now been hired and are at work on the wards.

(5) EFFORTS TO RELIEVE OVERCROWDING--As the Commission pointed out, many of the problems cited resulted from the overcrowding experienced at urban psychiatric centers. Since 1978, over 500 patients have been transferred from adult psychiatric centers in New York City to other state psychiatric centers outside the City. In 1984-85, a total of 209 patients will be transferred from four urban facilities. At the time of the May CQC site visits, these planned transfers had not occurred.

We appreciate the careful work which the Commission did in surveying conditions at the hospitals visited. The findings have been most helpful in improving conditions both in those facilities, as well as the entire system. However we suggest that the draft overview of the report be revised to reflect a more balanced view of the Commission's finding. Specifically, we recommend that the overview statement of the draft report be revised to reflect the following:

(1) The deficient conditions in 30 wards at the 5 centers should not be generalized to indict the entire system of 958 wards at 33 Psychiatric Centers. The Commission makes no note that the wards at centers visited are widely recognized to have the most challenging problems in our system. The language of the overview ("intolerable living conditions in state psychiatric centers") characterizes the entire system based on individual wards at those centers with the most difficult problems.

(2) The five facilities with the most serious conditions each serve proportionately higher numbers of young, acutely ill, aggressive patients. All of these urban centers face constant demand for service and are often overcrowded. Maintenance of a deteriorating capital plant with the limited staffing available is especially difficult at hospitals with large numbers of acutely ill patients, who tend to be destructive. The variability observed in the quality of the environment reflects differing abilities to meet the challenges of running each State Psychiatric Center and does not reflect differences in values.

(3) The problems cited by the Commission do not reflect a lack of standards. In addition to the standards contained in the New York State Constitution, Mental Hygiene Law, 14 NYCRR and the Office of Mental Health Policy Manual, the Office of Mental Health has adopted the standards of the Joint Commission on Accreditation of Hospitals. These standards are comprehensive, specific, clear, humane, and appropriate, and recognized nationwide.

We appreciate the Commission's effective advocacy on behalf of the mentally disabled and look forward to the final report.

Attachment II

Response by the Office of Mental Health (OMH) to Recommendations

by the Commission on Quality of Care for the Mentally Disabled (COC)

CQC Recommendation A.1

The Office of Mental Health should, as a matter of high priority, develop a clear and concise mission statement outlining minimum expectations of standards of care that all State psychiatric centers will achieve and maintain. This statement should specifically address the responsibility of these facilities to meet the basic human needs of patients, as well as to provide them with a minimum number of hours of constructive program or activity each day. Each facility should be annually evaluated by the Office of Mental Health against these standards of care and senior managers held accountable for their performance in these areas. Preferably, such evaluations ought to occur on an unannounced basis.

OMH Response

The mission statement for the Office of Mental Health as it relates to the care and welfare of the mentally ill in State operated psychiatric centers is stated in the Mental Hygiene Law. Specific examples from the Mental Hygiene Law illustrate this point:

§ 7.07.(c) The Office of Mental Health shall have the responsibility for seeing that mentally ill persons are provided with care and treatment, that such care, treatment and rehabilitation is of high quality and effectiveness, and that personal and civil rights of persons receiving care, treatment and rehabilitation are adequately protected.

§ 29.13 Treatment Plans

(a) Subject to the regulations of the Commissioner, the director of each departmental facility shall require the development of a written plan to assure adequate care and treatment for each patient.

(b) The written treatment plan shall include, but not be limited to, a statement of treatment goals; appropriate programs treatment or therapies to be undertaken to meet such goals; and a specific timetable for assessment of patient programs as well as for periodic mental and physical reexaminations ...

To operationalize this mission statement, it is the policy of the Office of Mental Health, that all State operated psychiatric centers seek and achieve accreditation from the Joint Commission on Accreditation of Hospitals. Thus, in effect, the Office of Mental Health has adopted the nationally recognized Joint Commission on Accreditation of Hospitals' Consolidated Standards as the minimum standards of care. The comprehensive JCAH criteria encompass four broad categories: program management, patient management, patient services and physical plant management, and are the generally accepted national professional standards. The JCAH is a highly respected organization of psychiatric and medical professionals and the value of its comprehensive accreditation program has been recognized by Congress and the courts. In fact, several courts have cited the JCAH accreditation criteria as a valid measure of adequate care.

To ensure that the minimum standards are being met, OMH is standardizing a system for monitoring the quality of the environment and personal care. This system exists in most facilities, and will be in place in all by December 31, 1984.

To initially address the minimum programming recommendation, the Office of Mental Health will require each facility to submit typical schedules of programming activities that are currently available for patients. After receiving this information from each facility, the Office of Mental Health will review the findings and develop recommendations for assuring that appropriate activities are available for patients. The recommendations will assist the Office of Mental Health in develping a range of programming activities that will be available for staff to use in planning and implementing each patient's treatment plan.

The Office of Mental Health will prepare a policy statement reaffirming that active programming is an integral component of the treatment process for psychiatric patients. Each facility will establish as a goal that the treatment planning process for each inpatient will include a specific assessment of active programming needs and active programming where appropriate will be prescribed and provided. The Office of Mental Health, under the direction of the Division of Clinical Programs, will develop more specific standards related to assessment and treatment of inpatients in State operated psychiatric facilities during fiscal year 1985-86.

This approach is based upon the following considerations:

- To prescribe a specific treatment standard or goal without recognition of the different needs among patients and the differing needs of the same patient over time is clearly not in the best interest of the patient. Not all patients necessarily need or can tolerate a precisely fixed number of hours of active programming each day. Some patients may need more hours and some patients may need less; and

- Rational staffing requirements are not based upon a prescription of rigidly fixed hours of treatment. Rather, as has been done in the new staffing standards for adult inpatient units, the basis for generating rational staffing requirements is the recognition that there are distinct patient groupings with distinct treatment and staffing needs. This method of developing rational staffing requirements recognizes that treatment is a complex process and that it must be individualized to the needs of each patient.

CQC Recommendation A.2

The Office of Mental Health should develop, on a priority basis, a policy that requires facilities to develop therapeutic treatment plans for patients which include therapeutic work activity addressing their needs to develop or maintain personal and self-care skills. Such plans may require that patients be given responsibility for housekeeping tasks in their living areas.

OMH Response

All OMH patients are required to have individualized comprehensive treatment plans. OMH utilizes existing resources to ensure that activities of daily living (ADL) skills such as laundry, cooking, personal hygiene, and bedmaking are performed by patients and are clearly incorporated into patients' treatment plans when appropriate. The OMH facilities also emphasize training in these areas as an integral part of ward programming. For example, work for pay programs, whereby patients are paid to perform various ward housekeeping tasks, clerical and errand work have been utilized with success by some facilities. The OMH will review these programs for their applicability on a Statewide basis.

In addition, many facilities have sheltered workshop programs and model apartments for training purposes. Facilities will be required to review these programs, and to assess their efficacy and to develop more work oriented programs to the degree possible with existing resources.

CQC Recommendation A.3

> Every State psychiatric center should be surveyed to identify deficiencies in the physical plant that directly impact upon living conditions for patients. An inventory of repairs, maintenance and capital projects should be developed, prioritized and scheduled. In this process, consideration should be given to temporarily regionalizing maintenance staff to address the most critical problem areas in a timely fashion.

OMH Response

Each psychiatric center will be asked to review and identify current physical plant deficiencies which impact upon the living conditions of patients. Those which are identified as capital projects will be submitted through the Regional Office to Central Office's Bureau of Capital Operations for either a budget request or immediate funding out of current capital appropriations. The listing of repairs and maintenance will be scheduled and reviewed by Regional Office staff to assure appropriate correction.

In the last year the OMH has established a new bureau within the Support Division to examine the deficiencies and needs of the therapeutic environment at all OMH centers. The mission of the Bureau of Safety and Environmental Services is to provide technical assistance to facilities in maintaining a safe and clean therapeutic environment.

This Bureau has undertaken pilot humanization enhancement projects at Kings Park PC and Kingsboro PC. The Kings Park Project was completed in July 1984 and the Kingsboro project is scheduled for completion in February 1985. These projects will act as a springboard for future organized humanization endeavors at all facilities.

We are in agreement that regionalized project teams are an effective tool in completing specific project type work. The OMH will pilot a project in the housekeeping/cleaning areas within the New York City region. By the end of this fiscal year a Central Office Housekeeping Technician and the Chief Housekeeper of each NYC facility will plan and schedule an

on-going cleaning project at each NYC center. The project crews will supplement the support staff at each of the facilities, and will assist in tasks that are either not being completed by facilities due to staff shortages or contract delays. This cadre of temporary cleaners will be used to ensure that project work is completed at each facility. The plan calls for the temporary cleaners to complete heavy duty cleaning such as stripping/washing of floors, window washing, and thorough cleaning of patient areas. This new method of operation will help to ensure that housekeeping standards are met throughout the year.

Similar regional projects are being planned in the support areas of painting, grounds, maintenance and physical plant for the 1985-1986 fiscal year.

COC Recommendation A.4

The Office of Mental Health should review the impact of reductions in work force upon facility operations which directly impact the quality of life for patients (e.g., food service workers, laundry clerks, recreation therapists, etc.) and, where necessary, request funds to operate at a level that meets the minimum standards of care identified in Recommendation No. 1.

OMH Response

This recommendation has been fully implemented. The Office of Mental Health has developed workload-based standards for Support Staffing in OMH facilities. The Support Staffing Standards which have been field tested and validated at every facility, now identify specifically the activities and staff required at state facilities.

The importance of an adequate level and mix of inpatient staff on the ward has also been recognized by OMH. The OMH has developed a new inpatient staffing system which determines the level and discipline mix of staff (including activity therapists) for eight patient groups. The system is based on the disability of the patient, performance and workload standards for inpatient staff and a multi-disciplinary approach to treatment.

COC Recommendation A.5

Facility directors, deputy directors for institutional administration, and other senior managers who have demonstrated skill in meeting and exceeding acceptable standards of care should be used as resources throughout the system in an effort to upgrade performance in vital areas affecting day-to-day living in psychiatric centers.

OMH Response

Facility directors, deputy directors for institutional administration, and other senior managerial personnel continue to be used outside their facilities throughout the mental health system to address major problems. Regional directors and senior facility management personnel historically have been utilized to assist facilities in solving problems. Currently, the Executive Directors of Manhattan and Capital District Psychiatric Center and the Regional Director for Long Island are providing technical assistance to Kingsboro. In addition, the Rochester Deputy Director for Institutional Administration is providing assistance to Buffalo.

Recently, a resource manual of facility support personnel with expertise in nutrition, housekeeping, grounds, maintenance, safety, utilities, communications and transportation was provided to Regional Directors for them to draw upon when expert personnel are needed in these areas. At Kingsboro Psychiatric Center, this practice has been operationalized. Each month support staff from other OMH facilities provide technical assistance to their Kingsboro counterparts.

COC Recommendation A.6

The Mental Hygiene Law should be amended to add a bill of rights for patients who reside in institutional settings, along the lines of the recently enacted bill of rights for the mentally retarded and developmentally disabled residents of community residential facilities (MHL §41.41). The law should provide that such a bill of rights be posted prominently on every ward of every facility and that the poster contains information on how to contact the facility Board of Visitors, the Mental Health Information Service and the Commission on Quality of Care if a patient believes his or her rights are being violated.

OMH Response

The Office of Mental Health supports the principle that patient rights should be articulated and that patients and staff should be aware of those rights. A number of specific rights are already set forth in the Mental Hygiene Law. In addition, there are several methods in place to inform patients of their rights and to facilitate communication between patients and groups or individuals overseeing the care of patients. Patients are informed, upon admission, of their basic legal rights, including the right to communicate with both the Mental Health Information Service, Board of Visitors and the Commission on Quality of Care for the Mentally Disabled. (A copy of this notice is attached.) In addition, free telephones are available to patients. OMH also prints and distributes a "Patients Right Handbook" - see attached.

COC Recommendation B.1

A high priority should be given to developing additional community residence beds in every catchment area of the State.

OMH Response

The Office of Mental Health has made expansion of the community residence program one of its major priorities.

Responding to the need to develop community residence beds, the Office of Mental Health has expanded this program from 300 to approximately 3,000 beds since 1978. The Governor, in his 1984 Annual Message to the Legislature, established the goal of expanding the community residence program over the next two years by 1,600 beds to address an identified need.

Until Fiscal Year 1984-85 the Community Residence program design included two program levels: supervised and supportive. The new program design implemented during Fiscal Year 1984-85 adds a third level, intensive supportive, to the residential continuum providing programming and funding to meet the specific needs of a diverse resident population.

To support the new model, the Office of Mental health worked cooperatively with the Legislature during the 1984 Legislative Session to amend Section 41.33, permitting a state share payment to community residence agencies of up to one hundred percent of operating costs.

The Office of Mental Health is expanding the community residence program in accordance with the Governor's recommendation. During Fiscal Year 1984-85 and Fiscal Year 1985-86 the existing two level program model will be converted to the new three-tiered housing and rehabilitative continuum which will provide a richer staffing pattern to serve the more disabled resident.

During this period of transition to a new service model, the Office of Mental Health is committed to maintaining the existing program at a level of funding adequate to provide high quality care. Community residence contracts were renegotiated with 76 provider agencies to maintain the existing program. To achieve the Governor's goal of a minimum 1,600 bed expansion over the next two years, OMH has instituted a planning strategy which will govern the general geographic location and bed type of new beds. This process will be used to create a rehabilitative housing service continuum of supervised, intensive supportive, and supportive housing in each area of the State. In addition, new program development grant guidelines were completed and implemented. These guidelines were designed to achieve planned program expansion goals by assisting community residence providers interested in developing new beds. It is expected that with the implementation of the new program model for community residences, there will be substantial bed development over the next two years.

COC Recommendations B.2

> The Office of Mental Health should seek to establish domiciliary care facilities in each region of the State to provide housing and aftercare services to patients who are ready for discharge from psychiatric centers but for whom there are inadequate resources in the community. Suitable vacant buildings on the grounds of State psychiatric center campuses are an option that should be explored for this purpose, consistent with the model developed at Creedmoor Psychiatric Center.

OMH Response

Over the past year, the Office of Mental Health has been involved in the development of a new, congregate care program called Residential Care Centers for Adults (RCCA). This program is an 80 to 200 bed, generally long stay, congregate housing program for those mentally ill persons not in need of inpatient care, but who do need supervision with the tasks of everyday living as well as on-site services to address the particular needs which are a result

of their mental disabilities. The development of the RCCA program is in response to the need for community-based residential and mental health treatment alternatives for special populations among the mentally ill, and is also a response to the limited access of the mentally ill to diminishing suitable housing in the state. The Residential Care Centers for Adults, in addition to providing long term care to mentally ill persons who function best in a congregate setting, are designed to augment the existing alternative living programs supported by the Office of Mental Health. Residents of RCCA programs will be periodically assessed for transitional potential and when appropriate, shall be provided additional assistance in moving to a more appropriate level of care.

In recognition of the emergent need in New York City for programming to address the particular needs of the homeless mentally ill and in conjunction with the Governor's statewide initiatives for the homeless, the first Office of Mental Health sponsored Residential Care Center for Adults has been developed on the grounds of Creedmoor Psychiatric Center. This particular program is designed to serve 196 "homeless" mentally ill and is co-located in Creedmoor's Building #4 with a New York City operated men's shelter and a voluntary agency operated mental health treatment service.

OMH is also designing a model RCCA program to serve a more generic population among the mentally ill. Most residents will be between ages 25-55, and all will be functionally disabled due to mental illness. It is expected that residents will come from a broad base of referral sources including State Psychiatric Centers. RCCA providers will be required to maintain linkages with appropriate community mental health and health services, and will make these services available to all residents. In initial years of development and operation, RCCA beds will be targeted, in large measure, to serve the mentally ill homeless. Since RCCAs represent a new program for the Office of Mental Health, a comprehensive evaluation will be performed during 1985-86. The outcome of evaluation efforts will guide the Office of Mental Health in making future modifications to the program if necessary as well as assist in policy decisions regarding future program development.

As has been past practice, OMH will continue to review the use of appropriate vacant buildings on State psychiatric center campuses for this and other levels of residential care.

COC Recommendation B.3

The Office of Mental Health should seek to develop additional crisis residences to assist each psychiatric center to deflect potential admissions that do not necessarily require acute hospitalization.

OMH Response

The OMH Bureau of Community Living is currently reviewing the Crisis Residence program. The review is designed to review the functions provided by the thirteen existing Crisis Residences, to review them in light of the original program guidelines, make recommendations incorporating the information gathered from existing programs on need, future goals, objectives, funding, and expanding the Crisis Residence program as part of the continuum of residential alternatives.

To date, a survey instrument of the current status and functioning of Crisis Residences programs has been sent and returned by all thirteen existing programs. Nine of the thirteen programs were chosen for site visits. The visits were completed by October 31, 1984. Information obtained from the surveys and visits is currently being compiled into a report on the current status, recommended changes in guidelines and procedures, as well as recommendations for expansion. The OMH expects that the recommendations on the program and frameworks for change and expansion will be available by mid-December, 1984.

The OMH supports continued development of on-grounds non-inpatient care that serves as a clinically appropriate alternative to inpatient care, or programs that, in a non-inpatient environment, prepare patients for community placement through the activity of teaching daily living skills. The review of the Crisis Residence program is intended to appropriately incorporate this program in the continuum of residential services and to clarify its role in that continuum, as a program for persons in "situational" rather than acute clinical crisis.

COC Recommendation B.4

Realistic program occupancy goals should be established for each psychiatric center, consistent with the resources available, to provide adequate patient care. For those centers that are currently above these occupancy goals, specific plans should be developed to reduce and eventually eliminate the overcrowding. One option that should be considered in the process is the transfer of consenting patients who do not have strong ties to the community to other facilities in the State providing equal or better conditions.

OMH Response

As noted in both the Commission's report and the Select Commission's Sub-Committee Report, State psychiatric centers often experience overcrowding due to factors outside their direct control. While realistic program occupancy goals have been established at each facility, their usefulness is limited because the State facilities cannot decline admissions of individuals in need of inpatient psychiatric care.

Overcrowding occurs most frequently in urban facilities where the demand for acute care is high. One method that OMH has successfully utilized to relieve the most serious overcrowding is the transfer of patients to other facilities in the State. For example, in New York City, where overcrowding due to acute admissions pressures occurs frequently at four of the five adult facilities, a process has been established to transfer appropriate patients to facilities in the nearby Hudson River Region. From 1978-1983, over 500 patients were transferred out of State psychiatric centers in New York City. In 1984-85, fifty patients from Manhattan have been transferred to Harlem Valley, 24 Bronx patients have been transferred to Rockland and 40 patients from Kingsboro are being transferred to Harlem Valley. Forty additional Kingsboro patients are to be transferred to Pilgrim PC, by 12/31/85. In addition, renovations underway at Bronx (requiring one-fourth of the facility be vacant for construction work at all times) have necessitated an even further reduction in patient census until renovations are completed. OMH with an agreement with the New York City Department of Mental Health is providing intermediate/long-term care to certain groups of Bronx residents in Rockland PC. To date, 47 Bronx residents have been admitted to Rockland. Overcrowding has also occurred in other urban facilities when the demand for acute services is high (Hutchings, Rochester, Buffalo and Capital District). Transfers to non-urban facilities in the same region has also been a successful mechanism to reduce census pressures for these facilities. For example, in FY 1984-85, Buffalo has transferred 40 patients to Willard and 15 to Gowanda.

Were it not for the natural deaths of our elderly patients, there would be a significant increase in the Statewide census. The issue for OMH is not simply the establishment of program occupancy goals, but the development of long-range plans and programs to meet the challenge and demands of a rising census of young, first admission, mentally ill persons. To accomplish this, OMH is developing a transfer plan between the New York City and Hudson River Regions to be fully implemented in the 1985-86 fiscal year. This plan will entail the on-going transfer of appropriate patients from overcrowded NYC facilities.

COC Recommendation B.5

The Office of Mental Health should consider accelerated development of day hospital programs to reduce the pressures for inpatient psychiatric care.

OMH Response

The Office of Mental Health is committed to the expansion of the current day treatment model as well as the development of a more intensive partial hospitalization model. Partial hospitalization has been demonstrated in a number of research studies to effectively act as an alternative to hospitalization, or as an adjunct to inpatient care. The Office of Mental Health and the Department of Health are jointly developing and funding the design of this program, with implementation targeted for 1985.

A statewide steering committee including representatives from OMH, DOH, local government and voluntary providers has been convened to develop the partial hospitalization model. As a preliminary step, a survey instrument will be completed by mid-December 1984, with field visits scheduled to begin in early 1985. Current and model programs will be examined. These will include not only state operated facilities, but also community mental health centers, general hospitals and municipal programs, and private programs--drawing an industry sample of partial hospitalization. Reimbursement methodologies will also be assessed in order to maximize the federal funding.

This model will be available for all Article 28 facilities and will allow for a major expansion in programs to dovetail with the community residential alternatives which are also under active residential development.

CQC Recommendations C.1, C.2, C.3

1. The Office of Mental Health should require every psychiatric center to create and utilize an internal review mechanism to periodically evaluate the facility against accreditation standards. Such evaluations ought to be conducted sufficiently frequently to ensure that standards are being continually maintained. Reports of these surveys should be made available to the facility director, the deputy director clinical, unit chiefs, and ward level staff, as well as the Regional Office and boards of visitors. The facility director should be held accountable for the implementation of any corrective actions identified as being necessary in these surveys.

2. Every psychiatric center should clearly establish person accountability at the ward level and at the unit level for living conditions which exist. There should be a specified individual on each shift who is personally accountable for ensuring that living conditions comply with the minimum standards that are established.

3. To facilitate clearer communication and priority setting with respect to housekeeping and maintenance at facilities, each facility should establish periodic meetings of clinical staff and maintenance/support staff.

OMH Responses

The OMH has redoubled its effort to monitor the quality of care in all its facilities. To accomplish this, OMH will implement by December 31, 1984, a uniform statewide monitoring system to ensure that the basic personal amenities, patient needs and living conditions provided to patients are consistent throughout the State. The monitoring process will occur at both the facility and the Regional Office level.

The OMH will develop a standardized system for monitoring the quality of the environment, personal care and active programming. This system is to be implemented on the ward level by the Unit Chiefs and Team Leaders on an on-going basis and will strengthen facility's current efforts in these areas. Corrective actions will occur immediately whenever possible.

In addition, each facility will utilize its Quality Assurance Committee for conducting monthly surveys of ward conditions along with compliance with JCAH and other patient care standards utilizing a standardized survey instrument. The facility director will be notified when any serious deficiencies are found, when the committee reports its findings and plans for corrective action, and when the committee's recommendations are not implemented and deficient conditions persist. The OMH will work with the Boards of Visitors to incorporate this monitoring system into their monthly facility site visits.

The Regional Office's responsibility in this process is to ensure that each facility's monitoring system is effective and implemented. The Regional Office staff will conduct monthly unannounced site reviews of a representative sample of all patient wards, determining how well patients' personal and treatment needs are being met. These reviews are already occurring in most Regions. Ward conditions and the facility monitoring process will also be reviewed at this time. An inventory of problem areas needing correction will be generated. The facility will respond with a plan of correction to be approved by the Regional Office. Quarterly reports of the monitoring process and of problem areas and corrective actions will also be sent to Central Office.

In addition to these actions, Central Office staff from the Operations and Support Divisions are conducting reviews with the Regional Offices at those facilities experiencing the most problems. Since September, this team has concentrated its efforts on the facilities most cited in the COC report. Follow-up reviews to assess facilities' progress in accomplishing recommendations are conducted. Central Office oversight of facilities compliance will continue as a routine course of action.

COC Recommendation D

The Office of Mental Health should arrange for representatives from several facilities to meet with purchasing agents at the Office of General Services to make clear the special needs of psychiatric centers for furniture and patient clothing. The need for such communication is particularly acute with respect for furnishing requirements for secure units and other units that house aggressive, acting out patients.

OMH Response

The Office of Mental Health is actively involved in the newly created Supply Support Customer Advisory Council which was formed after a complete study by the Governor's Council for Management and Productivity.

At the request of the Executive Chamber, the firm of Arthur Anderson and Company conducted a review of the linkages between the Office of General Services, Division of Supply Support, to the agencies who use their services.

Their report indicated that a serious communication problem existed with the primary New York State agencies and OGS, and recommended that a Supply Support Customer Advisory Council be formulated to address all problems in Purchasing, Food Delivery, Food Purchasing, Equipment Purchasing, Patient Clothing, Patient Linen Services and Patient Laundry Services. The primary focus was on how to better serve the client at the most efficient cost.

The Council was established in June, 1984 with four agencies represented as major council members: Office of General Services, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the Department of Corrections. In addition, all other New York State agencies that are users of OGS services sit on the committee as regular members.

The Office of Mental Health has taken an active role in the semi-monthly meetings of the Supply Support Customer Advisory Council to ensure that the special needs of the mentally ill are met. The Office of Mental Health Central Office Council Members are supported by five facility administrators (one from each region) who are regular members of the Council, and who are charged with providing facility input into issues of concern.

In addition, the Council has a full time Customer Service Manager who visits each facility throughout the state, collects complaints and problems, and presents these findings to the Council for action.

The OMH will solicit complaints and recommendations from selected facilities in order to present a uniform and comprehensive list of problems and needs to this council.

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-381-7098.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TTY)

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