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

December 1984

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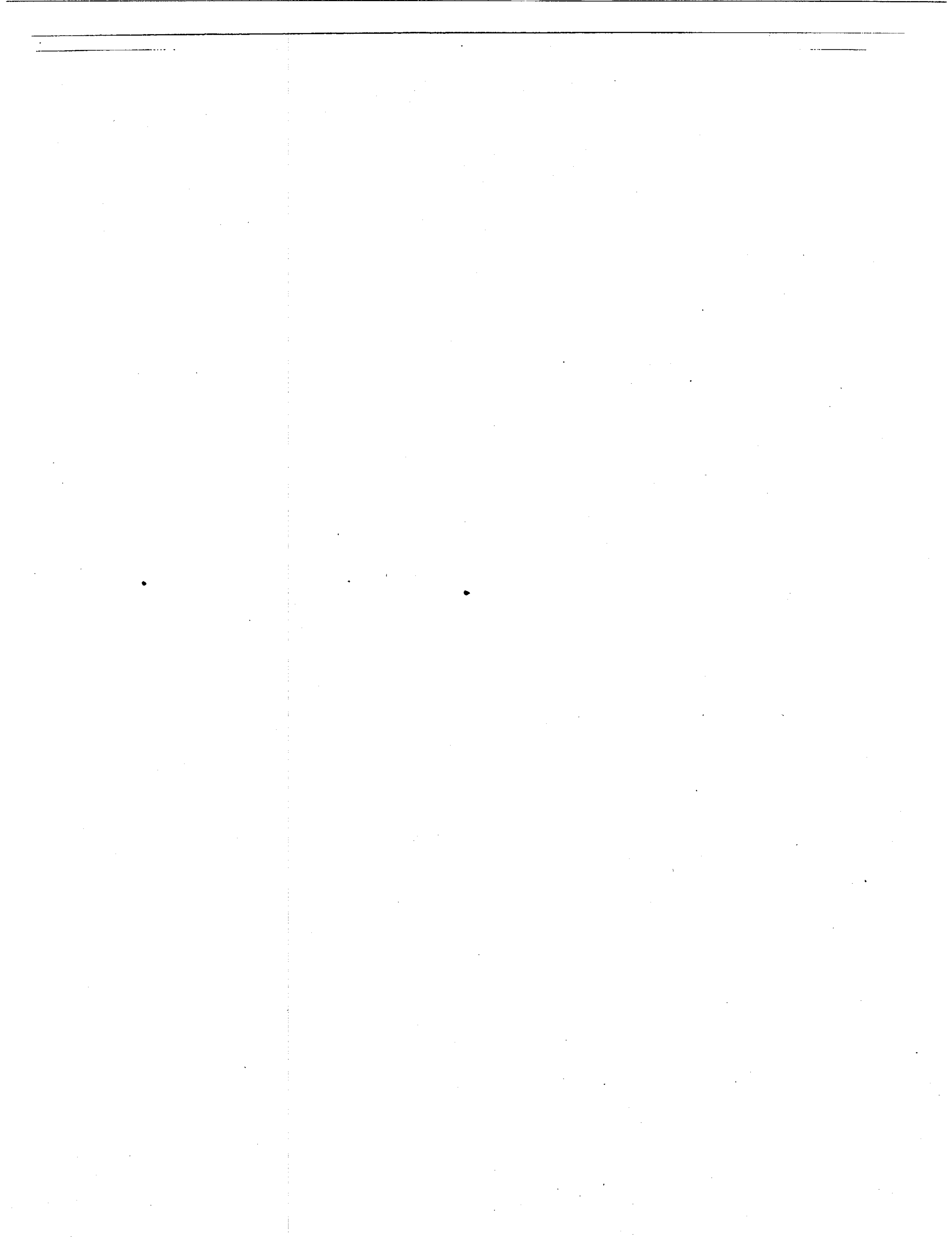
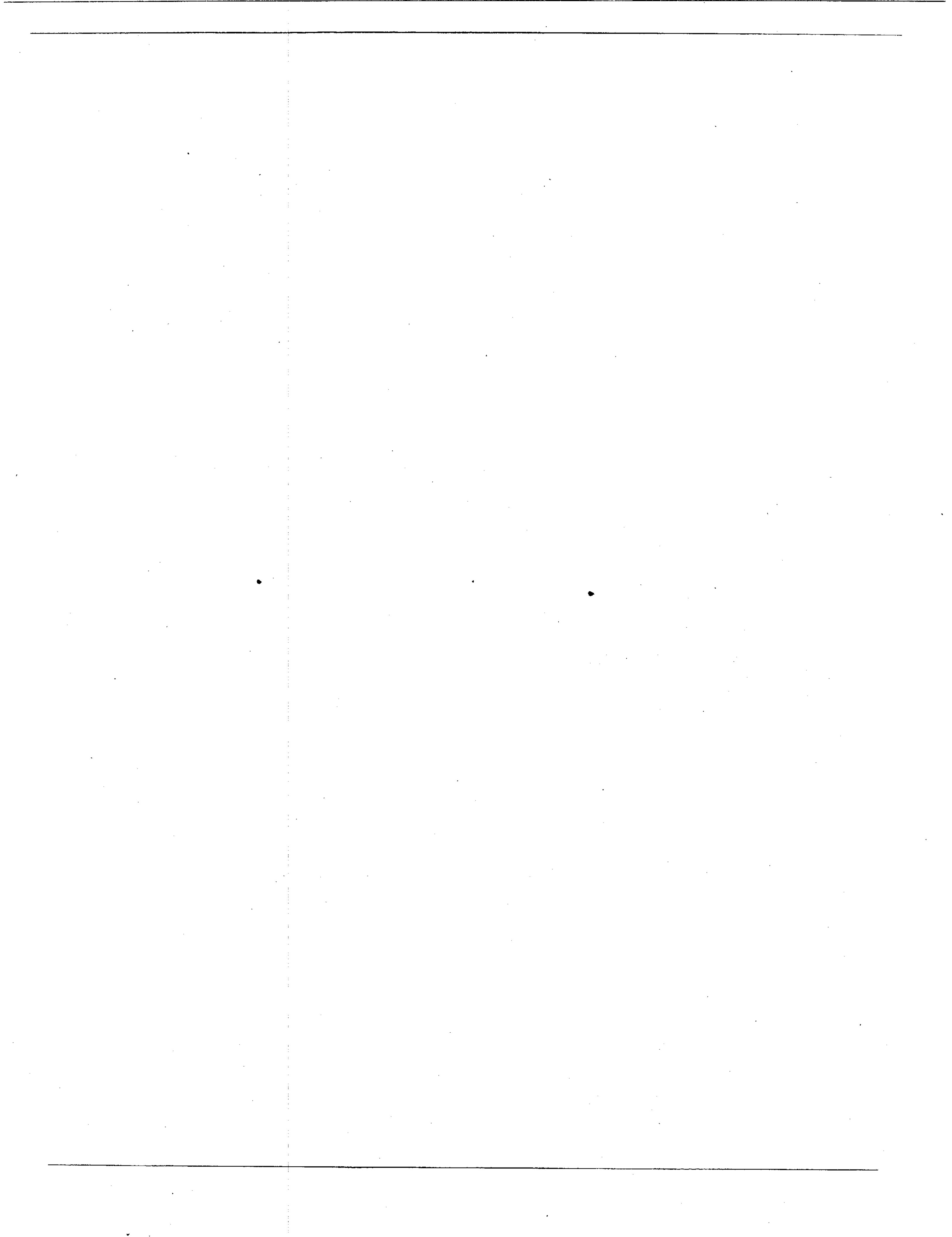


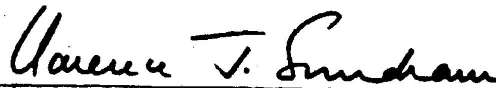


Preface

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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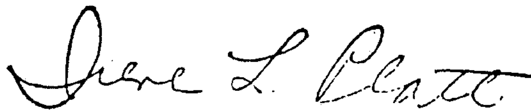

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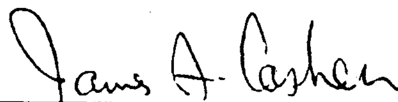

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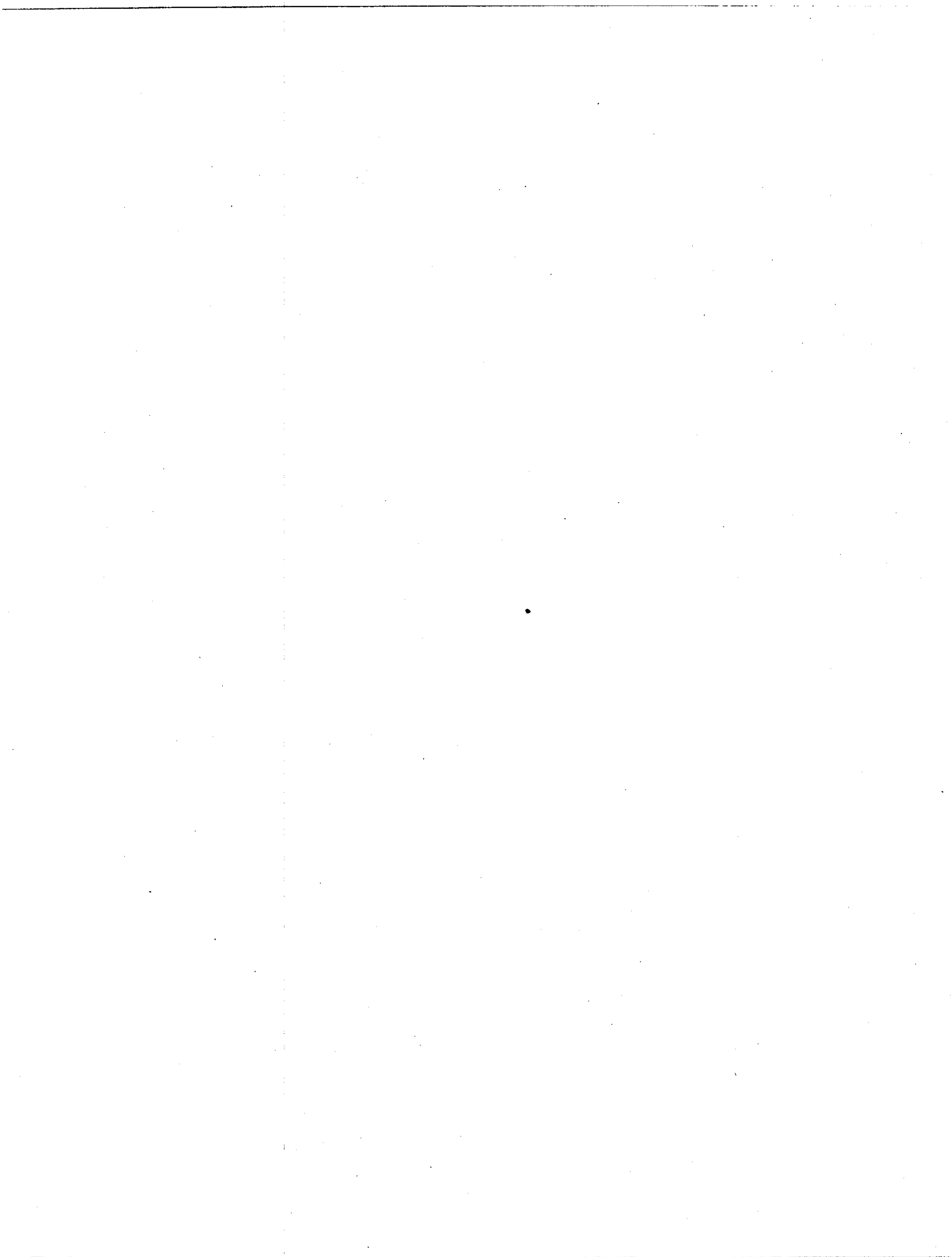

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Overview Statement and Recommendations

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 substandard 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 are 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 over-crowding 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.

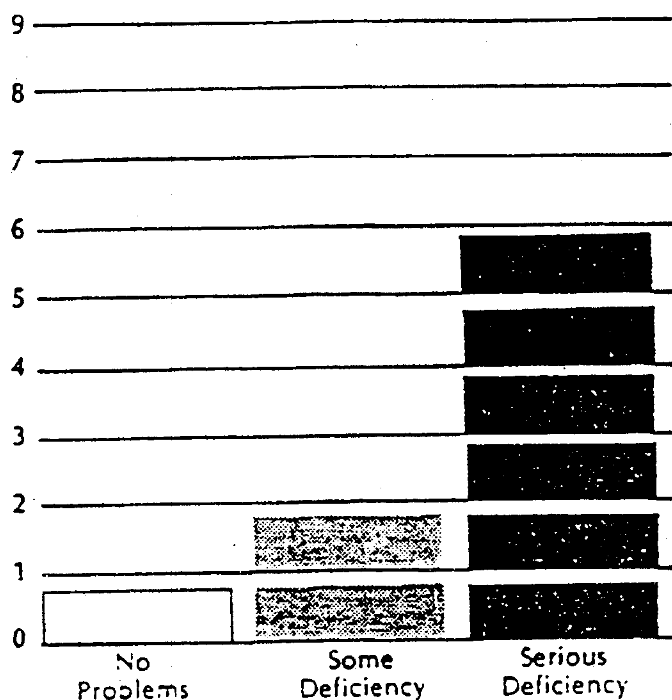
Throughout the presentation of the findings the significant variation in patient living conditions among the nine facilities and among different wards within the same facility is highlighted. In most of the visited facilities, these variations were striking. Some wards of State centers were found to 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.

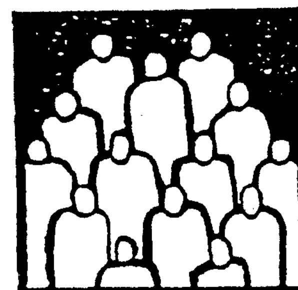
The Commission's conclusions and recommendations are outlined in Chapter III.

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.