NEW YORK STATE OF OPPORTUNITY.
Justice Center for the Protection of People with Special Needs

ANDREW M. CUOMO
Governor

DENISE M. MIRANDA
Executive Director

February 11, 2021

Dr. Li-Wen Lee
Associate Commissioner
Division of Forensic Services
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Anthony J. Annucci
Acting Commissioner
NYS Department of Corrections
And Community Supervision
The Harriman State Campus-Building 2
1220 Washington Avenue
Albany, NY 12226-2050

Re: [redacted] Justice Center Oversight Action

Dear Dr. Lee and Acting Commissioner Annucci:

The Justice Center for the Protection of People with Special Needs (the Justice Center) is required to oversee compliance with the Special Housing Unit (SHU) Exclusion Law and monitor the quality of corrections-based mental health care for inmate/patients (Chapter 1 of the Laws of 2008). To meet this mandate, we are conducting ongoing quality of mental health care reviews as well as SHU Exclusion Law compliance reviews to assess if the Office of Mental Health (OMH) programs within the Department of Corrections and Community Supervision (DOCCS) facilities conform to the requirements of the SHU Exclusion Law.

On February 12, 2020, the Justice Center conducted a site visit at the Bedford Hills Correctional Facility's Therapeutic Behavioral Unit (TBU) to review the quality of mental health care provided to inmate-patients in accordance with the SHU Exclusion Law, OMH policies, and DOCCS directives. The attached review details the Justice Center's findings and recommendations.

The Justice Center looks forward to your response to the attached findings and recommendations by March 11, 2021. Please direct any correspondence or concerns related to this review to me at denise.miranda@justicecenter.ny.gov. Thank you for your continued cooperation.

Sincerely,

Denise M. Miranda, Esq.
Executive Director

Cc: Davin Robinson, Deputy Director, Outreach, Prevention & Support
Melissa Finn, Unit Director, Forensics
Angelina LoCascio, Facility Review Specialist, Forensics
Dr. Anne Sullivan, M.D., Commissioner, OMH
Deborah McCulloch, Executive Director, CNYPC
William Vertoske, Forensic Services Program Administrator 2, OMH
Maureen Morrison, OMH
Meaghan Bernstein, OMH
Bryan Hilton, Associate Commissioner, DOCCS

NOTE: All correspondence related to this matter will be available for public inspection under Article 6 of the Public Officers Law. Material which will be required to be kept confidential or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to such disclosure.

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Review of Justice Center Oversight Action
Bedford Hills Correctional Facility Therapeutic Behavioral Unit
Quality of Mental Health Care Review
JC#: [redacted]

On February 12, 2020, the Justice Center for the Protection of People with Special Needs (the Justice Center) conducted a site visit at the Bedford Hills Correctional Facility Therapeutic Behavioral Unit (TBU) to review the quality of mental health care provided to inmate-patients in accordance with the SHU Exclusion Law, Office of Mental Health (OMH) policies, and Department of Corrections and Community Supervision (DOCCS) directives. [1]

The Justice Center toured the TBU Unit Program Area and spoke cell-side with eight inmate/patients. [2] The Justice Center reviewed the quality of corrections-based mental health care provided to nine inmate-patients in the TBU. Justice Center staff requested private interviews and four individuals chose to speak with us. [3] Furthermore, we examined clinical documentation, DOCCS guidance records, and reviewed the DOCCS Sign-In Log Book and Unit Activity Log Book.

In addition to reviewing the OMH clinical case record and the DOCCS guidance record, Justice Center staff also requested any exceptional circumstances documentation for inmate-patients who were in the TBU at any point during the Justice Center's six-month review period. [4] According to information provided to the Justice Center by the Bedford Hills CF TBU, there were 10 inmate-patients placed on Exceptional Circumstances (EC) during our review period.

These findings were based on documentation received from both DOCCS and OMH regarding the Bedford Hills CF TBU. The Justice Center flagged all required documentation for review at the Bedford Hills CF on February 12, 2020. In addition, the Justice Center provided OMH Central Office with a list of all required documentation on February 14, 2020 via email. Our findings from this review are outlined below.

Justice Center Findings:

1. **Between August 2019 to February 2020, 73% of the Informational Reports issued at the Bedford Hills CF TBU were positive.**

   The Justice Center requested all Informational Reports written during the review time period and were provided with 74 total Informational Reports. Of the 74 Informational Reports that were issued to inmate/patients, 54 were positive, 17 were negative, and

[1] Correction Law §§137(6)(d) and (e), 401.
[2] The census at the time of the Justice Center's visit was nine inmate/patients. The Justice Center met cell side with eight inmate/patients, as one inmate/patient was in the RCTP during the Justice Center's site visit. Her DOCCS Guidance Record and OMH Clinical Record were included in our sample of inmate-patients.
[3] Justice Center staff offered six private interviews for inmate/patients at the Bedford Hills CF TBU. Four inmate/patients chose to meet with Justice Center staff privately, while two inmate/patients declined. Three inmate/patients, which were included in our Quality of Mental Health sample were not present in the TBU and could not be asked if they wanted to participate in a private interview.
[4] The Justice Center's review period for this review was August 1, 2019 to February 12, 2020.

three were classified as "other behavior." The Justice Center found that not only did the positive Informational Reports exceed the negative and other Informational Reports, but that most of the positive Informational Reports were written for inmate-patients who not only had a significant history of challenging behaviors, but consistently displayed those same challenging behaviors in the TBU. Utilizing Informational Reports to encourage positive behavior through incentives and positive reinforcement is one of the behavior interventions used in a special program. Following a review of the Bedford Hills CF ICP in November 2017, the Justice Center noted "It was apparent that DOCCS and OMH staff communicate with one another and provide a therapeutic environment intended for those residing in a special program," and it is evident that this level of interaction and collaboration between DOCCS and OMH occurs in the TBU as well and they should be commended for their efforts.

2. **Residential Crisis Treatment Program (RCTP) Observation Referral to Clinical Director/Designee documentation for [redacted] (DIN [redacted]) was not completed according to policy and observation and progress notes were missing for eight days while she was in the RCTP. [5]**

[redacted] was admitted to the RCTP on [redacted] 2019 after she attempted to hang herself with a sheet at the same time as a peer and threw suspicious liquid on the officer who tried to help her. Due to her unpredictable behavior, including threatening self-harm and storing full cups of urine in her cell, [redacted] was not discharged from the RCTP until [redacted] 2019.[6] Per documentation received by the Justice Center, the only RCTP Observation Referral to Clinical Director/Designee completed for [redacted] is dated [redacted] 2019. It was documented that [redacted] "was approved for continued OBS admission." Although there are RCTP Nursing Progress Notes documenting that [redacted] continued to be housed in the RCTP, there were no RCTP Observation/Dorm Progress Notes in her clinical record for the following dates leading up to her discharge back to the TBU: [redacted] 2019, [redacted] 2019, [redacted] 2019, and [redacted] 2019.

3. **There were discrepancies between Psychiatric Progress Notes and Physician's Orders for two inmate-patients. [7], [8]**

   - [redacted] (DIN [redacted]) November 26, 2019 Psychiatric Progress Note documented that she had been recently released from Central New York

[5] CBO Policy #9.30- Progress Notes, states the following for RCTP admissions:
Primary Therapist/RCTP Coordinator:
- RCTP Observation/Dorm Initial Progress Note (MED CNYPC 360) upon initial interview for patients in both the Observation Cells and Dorm.
- RCTP Observation/Dorm Progress Note (MED CNYPC 360A) due daily thereafter for patients in Observation, and weekly for those in Dorm.
- RCTP Observation Referral to Clinical Director/Designee Progress Note (MED CNYPC 358) - required upon CNet-CBO e-mail notification that an inmate-patient has been housed in an RCTP Observation Cell in excess of seven days. Should the CNet-CBO e-mail notification occur on a weekend or holiday, this progress note must be completed on the next business day. Additional subsequent RCTP Observation Referral to Clinical Director/Designee Progress Notes are completed every seven days from the date of the original consultation for the duration of an inmate-patient's stay in an RCTP Observation Cell.
[6] According to [redacted] RCTP Monitoring Chart she was admitted to the RCTP on [redacted] 2019 at 3:00 p.m. after her trip to an [redacted] and transferred off observation status on [redacted] 2019 at 1:00 p.m.
[7] CBO Policy #9.27- Psychiatric Progress Notes, states, psychiatric staff must "Document at each subsequent visit all current psychiatric medications and any changes in medical medications noted at the time of the most recent admission or transfer."
[8] This was noted as a concern at the Bedford Hills CF when the Justice Center reviewed both the Bedford Hills CF ICP in November 2017 and the Albion CF in July 2019. Please review findings letters from those site visits for reference.

Psychiatric Center (CNYPC) and was prescribed [redacted]. A Psychiatric Progress Note from the RCTP dated [redacted] 2019 noted that her [redacted] would be increased due to [redacted]. However, [redacted] was not prescribed [redacted]. The progress note also indicated that she was to be prescribed [redacted] "for [redacted]." Her Physician's Orders also dated November 27, 2019; state [redacted] was to increase to [redacted].

- [redacted] (DIN [redacted]) entered Reception at the Bedford Hills CF on September 23, 2019 with a prescription for [redacted], which was discontinued the following day according to her September 24, 2019 Physician's Orders. On September 27, 2019, she met with psychiatric staff and the progress note states that [redacted] was part of her medication regimen, despite having been discontinued. When [redacted] met with psychiatric staff on September 30, 2019, [redacted] had been removed from her medication regimen in the psychiatric progress note.

Justice Center Recommendations:

1. Please provide the Justice Center with documentation demonstrating an RCTP Observation Referral to Clinical Director/Designee and RCTP Observation/Dorm Progress Notes were completed for [redacted], if applicable. Should OMH determine an RCTP Observation Referral to Clinical Director/Designee and RCTP Observation/Dorm Progress Notes were not completed according to policy, please review CBO Policy #9.30 with the appropriate staff at the Bedford Hills CF.

2. The Justice Center requests that OMH staff members be retrained in CNYPC CBO Policy #9.27- Psychiatric Progress Notes to ensure staff members understand the importance of correct documentation of psychiatric medications to maintain continuity of care. In addition, the OMH Clinical Director should initiate a review process to ensure accuracy in medication documentation between all areas of the clinical case record.

Review conducted by: _____
Angelina LoCascio, Facility Review Specialist

[redacted]

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

ANDREW M. CUOMO
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

CHRISTOPHER TAVELLA, Ph.D.
Executive Deputy Commissioner

March 18, 2021

Denise M. Miranda, Esq.
Executive Director
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054

Dear Ms. Miranda:

We received your letter dated February 11, 2021 in response to the Justice Center's February 12, 2020 site visit to the Bedford Hills Correctional Facility (CF) Therapeutic Behavioral Unit (TBU) to determine the quality of mental health care provided to inmate-patients, and determine compliance with the Special Housing Unit (SHU) Exclusion Law, the Office of Mental Health's (OMH) policies, and the Department of Corrections and Community Supervision's (DOCCS) directives.

Below are the Justice Center's findings and recommendations, from the above-referenced review, and OMH's response to each. The related documentation is enclosed.

Recommendation #1:
"Please provide the Justice Center with documentation demonstrating an RCTP Observation Referral to Clinical Director/Designee and RCTP Observation/Dorm Progress Notes were completed for [redacted] if applicable. Should OMH determine an RCTP Observation Referral to Clinical Director/Designee and RCTP Observation/Dorm Progress Notes were not completed according to policy, please review CBO Policy #9.30 with the appropriate staff at the Bedford Hills CF."

OMH Response:
Residential Crisis Treatment Program (RCTP) Observation progress notes were completed for [redacted] on all the dates indicated by the Justice Center, with the exception of November 11, 2019 as that was a state-recognized holiday and therefore mental health staff were not on site. The progress notes are enclosed with this response.

CNYPC CBO Policies #4.0 RCTP Observation Cells and Dormitory Beds and #9.30 Progress Notes were recently updated and it is no longer a requirement that staff complete separate RCTP Observation Referral to Clinical Director/Designee Notes. Therefore, policy was not reviewed with staff. Instead, mental health staff were reminded of the importance of ensuring RCTP consults are submitted in a timely manner. Copies of the updated policies are enclosed with this response.

Recommendation #2:
"The Justice Center requests that OMH staff members be retrained in CNYPC CBO Policy #9.27-Psychiatric Progress Notes to ensure staff members understand the importance of correct documentation of psychiatric medications to maintain continuity of care. In addition, the OMH

Clinical Director should initiate a review process to ensure accuracy in medication documentation between all areas of the clinical case record."

OMH Response:
Regarding [redacted] ([redacted]) case, while the psychiatrist did inadvertently write [redacted] in her progress note, OMH would like to note that this error did not make it to the psychiatric medication list section of the progress note or the Physician's Order and, therefore, the patient received the correct medication. Nonetheless, the Supervising Psychiatrist reviewed with the prescriber assigned to [redacted] and [redacted] cases the importance of comparing progress notes against Medication Administration Records and previous orders to ensure documentation is accurate. As this is not directly addressed in CNYPC CBO Policy #9.27 Psychiatric Progress Notes, OMH determined a review of policy was not indicated.

We thank you for bringing your concerns to our attention.

Sincerely,

Li-Wen Lee, M.D.
Associate Commissioner
Division of Forensic Services

cc: Danielle Dill, Psy.D., Executive Director, CNYPC
William Vertoske, Deputy Director, Corrections Based Operations, CNYPC
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