



**Justice Center for the
Protection of People
with Special Needs**

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

June 17, 2022

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 incarcerated individuals (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 November 10, 2021, the Justice Center's Forensic Unit conducted a site visit at the Five Points Correctional Facility Residential Mental Health Unit (RMHU) to review the quality of mental health care provided to incarcerated individuals 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 July 18, 2022. Please direct any correspondence or concerns related to this review to me at davin.robinson@justicecenter.ny.gov. Thank you for your continued cooperation.

Sincerely,



Davin Robinson
Deputy Director, Office of Outreach, Prevention & Support

Cc: Davin Robinson, Deputy Director, Outreach, Prevention & Support
Nikki O'Meara, Director of Operations, Forensics
Melissa Finn, Director of Quality and Compliance, Forensics
Angelina LoCascio, Facility Review Specialist, Forensics
Dr. Anne Sullivan, M.D., Commissioner, OMH
Danielle Dill, Executive Director, CNYPC
William Vertoske, Deputy Director Psychiatric Center 2, Corrections-Based Operations
Lisa Murphy, Acting Director of Quality Management, OMH
Maureen Morrison, OMH
Meaghan Bernstein, Advocacy Letter Coordinator
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.



KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

**Review of Justice Center Oversight Action
Five Points Correctional Facility RMHU
Special Housing Unit (SHU) Compliance / Quality of Care
JC#: [REDACTED]**

On November 10, 2021 the Justice Center for the Protection of People with Special Needs (the Justice Center) Forensic Unit conducted a site visit at the Five Points Correctional Facility's (CF) Residential Mental Health Unit (RMHU) to review the quality of mental health care provided to incarcerated individuals, and determine compliance with the SHU Exclusion Law, Office of Mental Health (OMH) policies, and Department of Corrections and Community Supervision (DOCCS) directives.¹ At the time of the site visit, there were 51 incarcerated individuals in the SHU and all individuals were on the mental health caseload and designated MHS 1S.

In addition to reviewing the OMH clinical case record, DOCCS SHU folders, and DOCCS guidance record, the DOCCS Sign-In Logbook and Unit Activity Logbook, the Justice Center also requested any Exceptional Circumstances documentation for a time-period of six months.

Compliance Determination:

To assess compliance, the Forensic Unit toured the RMHU and spoke cell side with 51 incarcerated individuals. We also reviewed the records of five incarcerated individuals to determine whether the facility was in compliance with the conditions of the SHU Exclusion Law:

- 1. Upon placement of an inmate into segregated confinement at a level one or level two facility, a Suicide Prevention Screening Instrument shall be administered by staff from the Department or the Office of Mental Health who has been trained for that purpose;*
- 2. Within one business day of the placement of such an inmate into segregated confinement at a level one or level two facility, the inmate shall be assessed by a mental health clinician;*
- 3. If an inmate with a serious mental illness is not diverted or removed to a residential mental health treatment unit, such inmate shall be reassessed by a mental health clinician within fourteen days of the initial assessment and at least once every fourteen days thereafter;*
- 4. Inmates with serious mental illness who are not diverted or removed from segregated confinement shall not be placed on a restricted diet, unless there has been a written determination that the restricted diet is necessary for reasons of safety and security. If a restricted diet is imposed, it shall be limited to seven days, except in the exceptional circumstances where the joint case management committee determines that limiting the restricted diet to seven days would pose an unacceptable risk to the safety and security of inmates or staff. In such case, the need for a restricted diet shall be reassessed by the joint case management committee every seven days; and,*

¹ Correction Law §§137(6)(d) and (e), 401.

5. *All inmates in segregated confinement in a level one or level two facility who are not assessed with a serious mental illness at the initial assessment shall be offered at least one interview with a mental health clinician within fourteen days of their initial mental health assessment, and additional interviews at least every thirty days thereafter, unless the mental health clinician at the most recent interview recommends an earlier interview or assessment.*

The Justice Center's review found there were five incarcerated individuals placed on exceptional circumstances during the review period. Based upon our review the Justice Center has made a determination that the Five Points CF RMHU was in compliance with the SHU Exclusion Law.

Quality of Mental Health Care

The Justice Center also reviewed the quality of corrections-based mental health care provided to 20 individuals in the RMHU. To complete a thorough evaluation, Justice Center staff requested 10 private interviews in the SHU and seven incarcerated individuals chose to speak with the Justice Center.

Justice Center Findings

1. **During the six-months reviewed by the Justice Center, 87% of the Informational Reports issued at the Five Points CF RMHU were positive.**

The Justice Center requested all Informational Reports written for the review time period and were provided with a total of 157 Informational Reports. Of the 157 Informational Reports that were issued to individuals, 137 were positive. The use of positive informational reports providing positive feedback to incarcerated individuals helps support a therapeutic environment. Incarcerated individuals received positive informational reports for perfect attendance at group programming, completion of extra in-cell work, positive group participation, and attending call outs.

2. **Three incarcerated individuals were placed on Exceptional Circumstances without the appropriate documentation about when they were taken off Exceptional Circumstances.**

- Incarcerated Individual 1 was placed on Exceptional Circumstances on August 18, 2021 and October 20, 2021 with restrictions on property, services, and privileges, specifically his state razor or nail clippers due to self-harm.² There is no indication on either form when they were removed from Exceptional Circumstances.

The Justice Center also received documentation that Incarcerated Individual 1 was also placed on Exceptional Circumstances on November 2, 2020. Since the Justice Center requested documentation for the six months prior to our visit in November 2021, it is unknown if it is a typo or the wrong document, but it is dated November 2, 2020 and the end date is also documented as December 2,

² [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 1.

2020. It was noted they would have restrictions on property, services, and privileges for security purposes, specifically their state razor or nail clippers due to self-harm. Documentation demonstrates their Exceptional Circumstances were not reviewed until December 2, 2020 and it recommended the "continuation of razor/nail clipper restriction for safety and security of inmate and unit."

- Incarcerated Individual 2 was placed on Exceptional Circumstances on April 2, 2021.³ They were caught stealing ICP property and their out of cell programming and treatment was restricted due to concerns regarding safety and security. Their Exceptional Circumstance status was reviewed on April 16, 2021 and it was determined their previous actions created an unsafe environment in the ICP and they remained on Exceptional Circumstances. There is no documentation demonstrating that they were removed from Exceptional Circumstance status.

Incarcerated Individual 2 again was placed on Exceptional Circumstances on October 20, 2021. It was noted they would have restrictions on property, services, and privileges for security purposes, specifically their state razor or nail clippers due to self-harm. There is no indication when they were removed from Exceptional Circumstances status.

- Incarcerated Individual 3 was placed on Exceptional Circumstances on October 20, 2021.⁴ It was noted they would have restrictions on property, services, and privileges for security purposes, specifically their state razor or nail clippers due to self-harm. There is no indication as to when they were removed from Exceptional Circumstance status.

3. Multiple incarcerated individuals refused to meet with psychiatric staff in the months leading up to the Justice Center's site visit, so it is unclear when they were evaluated by psychiatric staff.⁵

- Incarcerated Individual 4 was scheduled to meet with psychiatric staff via Video Tele-Conferencing (VTC) on October 19, 2021, November 2, 2021, and November 9, 2021 but refused to attend their call outs.⁶
- According to Primary Therapist Progress Notes, Incarcerated Individual 5 was scheduled to meet with psychiatric staff via VTC on October 28, 2021 and November 4, 2021 but refused to attend their call outs.⁷

³ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 2.

⁴ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 3.

⁵ CBO Policy #2.4 Cancelled/Missed/Refused Call Outs states, "When Mental Health callouts are missed for any reason, the staff person with whom the patient missed the appointment will review the inmate-patient's mental health record the next time they are on site and reschedule the callout for an appointment within two (2) weeks, or sooner if clinically indicated. Should an inmate-patient miss the re-scheduled mental health callout, a Mental Health clinician will conduct a "face-to-face" visit with the inmate-patient within three (3) business days of the missed rescheduled callout."

⁶ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 4.

⁷ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 5.

- On August 23, 2021, Incarcerated Individual 6 transferred from the Great Meadow CF BHU to the Five Points CF RMHU.⁸ They were scheduled to meet with psychiatric staff on September 7, 2021, September 14, 2021, September 21, 2021, September 28, 2021, October 5, 2021, October 19, 2021, October 26, 2021, November 2, 2021 and November 9, 2021 via VTC but refused to attend their call out.
- Incarcerated Individual 7 transferred to the Five Points CF RMHU on August 16, 2021.⁹ They were scheduled to meet with psychiatric staff via VTC on August 31, 2021, September 28, 2021, and October 5, 2021 but refused to attend their call outs. Their next contact with psychiatric staff was via VTC on October 19, 2021.
- Incarcerated Individual 8 transferred from the Wende CF SHU to the Five Points CF RMHU on October 7, 2021.¹⁰ They were scheduled to meet with psychiatric staff on October 26, 2021 but could not attend as he was out of the facility. They refused to attend their psychiatric call out on November 2, 2021. Per Physician's Orders, their morning dose of [REDACTED] was discontinued due to refusals and the [REDACTED] remained the same. Their [REDACTED] was also discontinued, and [REDACTED] was prescribed with a [REDACTED].

A six-month review of DOCCS and OMH records often includes records of treatment that an incarcerated individual received at another correctional facility before being transferred to the correctional facility reviewed. The findings below do not pertain to the Five Points CF RMHU:

4. While at the Auburn CF, Incarcerated Individual 5 was not escorted to their scheduled appointment.

Incarcerated Individual 5 was supposed to meet with mental health staff on August 31, 2021 but was not escorted to their appointment. It was noted they were going to be rescheduled for September 14, 2021, however, their next contact with mental health staff was on September 13, 2021 for an intake assessment after they were admitted to the SHU.

5. While at the Great Meadow CF Behavioral Health Unit (BHU), Incarcerated Individual 6 did not meet with mental health staff according to policy.¹¹

Per documentation received by the Justice Center, Incarcerated Individual 6 did not meet with mental health staff in June 2021 or July 2021. Their next contact with mental health staff was on August 7, 2021 when they were admitted to the RCTP due to threats of self-harm.

⁸ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 6.

⁹ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 7.

¹⁰ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 8.

¹¹ CBO Policy #9.30 Progress Notes states, "GENERAL POPULATION, ICP, IICP, Tr-ICP, BHU, TBU, RMHU, and CORP: MHSL 1 and all S designated: monthly."

6. While at the Walsh Regional Medical Unit (RMU), Incarcerated Individual 5 did not meet with mental health staff according to policy.¹²

Incarcerated Individual 5 was scheduled to meet with mental health staff on July 22, 2021 but refused to attend their private call out. It was documented in the progress note that they had stated in the past that he did not want to be on the mental health caseload and did not wish to attend call outs. They were scheduled to meet with mental health staff on August 3, 2021 but refused to attend their private call out. Again, they stated they did not want to be on the mental health caseload.

7. While at the Attica CF Transitional Intermediate Care Program (TrICP), Incarcerated Individual 1 did not meet with mental health staff according to policy.¹³

There is no documentation demonstrating Incarcerated Individual 1 met with mental health staff in June 2021 while at the Attica CF TrICP. Per documentation provided to the Justice Center, their next contact with mental health staff was on July 16, 2021 for an intake assessment upon admission to the SHU.

8. While at the Attica CF, Incarcerated Individual 1 and Incarcerated Individual 9 were not assessed by mental health staff according to guidelines delineated in the SHU Exclusion Law.¹⁴

- Incarcerated Individual 1 was admitted to the Attica CF SHU on July 15, 2021. An intake assessment was conducted with them on July 16, 2021. Per documentation received by the Justice Center, a 14-day assessment was not conducted with them within the appropriate timeframe. Their next contact with mental health staff was not until August 13, 2021 following a transfer to the Wende CF Step Down Program (SDP). They arrived at the Five Points CF RMHU on August 17, 2021 and met with mental health staff upon arrival.
- According to Incarcerated Individual 9's Chronological Record, they were admitted to the SHU from the ICP on August 28, 2021. Per documentation received by the Justice Center, there is no documentation demonstrating an intake assessment was conducted. Their next contact with mental health staff was on September 8, 2021 when they were admitted to the RCTP due to threats of self-harm.

Incarcerated Individual 9 was discharged from the RCTP to the SHU on [REDACTED] 2021 per a RCTP Observation/Dorm Initial Progress Note and their Chronological Record. According to the records supplied to the Justice

¹² CBO Policy #2.4 Cancelled/Missed/Refused Call Outs states, "When Mental Health callouts are missed for any reason, the staff person with whom the patient missed the appointment will review the inmate-patient's mental health record the next time they are on site and reschedule the callout for an appointment within two (2) weeks, or sooner if clinically indicated. Should an inmate-patient miss the re-scheduled mental health callout, a Mental Health clinician will conduct a "face-to-face" visit with the inmate-patient within three (3) business days of the missed rescheduled callout."

¹³ CBO Policy #9.30 Progress Notes states, "GENERAL POPULATION, ICP, IICP, Tr-ICP, BHU, TBU, RMHU, and CORP: MHSL 1 and all S designated: monthly."

¹⁴ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 9.

Center, they did not meet with mental health staff for their intake assessment in the SHU until September 20, 2021.

9. While at the Elmira CF, there was a discrepancy between the Psychiatric Progress Note and Physician's Order for Incarcerated Individual 10.¹⁵

Psychiatric staff met with Incarcerated Individual 10 via VTC on September 29, 2021. They stated, I'm gonna stick with the same meds for now" and added "I'm still moody." Per the Psychiatric Progress Note, they were prescribed [REDACTED] for 14 days, then increased to [REDACTED] thereafter, [REDACTED]. Physician's Orders dated September 29, 2021, however, indicate they were prescribed [REDACTED]. All other medications listed in the Physician's Orders match what was written in the Psychiatric Progress Note.

10. While at the Elmira CF, Incarcerated Individual 10 was not seen by mental health staff according to policy.¹⁶

Per documentation received by the Justice Center, Incarcerated Individual 10 was not seen by their primary clinician for mental health call outs in June 2021, July 2021, August 2021, and September 2021. Their next contact with mental health staff is on October 14, 2021 when they were admitted to the Elmira CF RCTP due to threats of self-harm.

11. Incarcerated Individual 8 was not seen by psychiatric staff at the Green Haven CF according to policy following a transfer.¹⁷

Incarcerated Individual 8 met with psychiatric staff at the Green Haven CF on July 8, 2021 and requested to have their morning medications restarted due to symptoms of [REDACTED]. They were prescribed [REDACTED].

[REDACTED] transferred from the Green Haven CF to the Wende CF on August 9, 2021. They were scheduled to meet with psychiatric staff on September 16, 2021 but "did not show up" for the call out.¹⁸ They were rescheduled for September 28, 2021 and refused the call out, "as per officer."¹⁹ Although there was a Physician's Order completed on October 6, 2021 for continuation of their medication regimen, it appears that they did not get the opportunity to speak with psychiatric staff at all during their time at the Wende CF because they transferred to the Five Points RMHU on October 7, 2021.

Justice Center Recommendations:

1. The Justice Center commends the Five Points CF RMHU for issuing positive Informational Reports. Informational Reports are important because they assist the

¹⁵ [REDACTED] (DIN [REDACTED]) is hereinafter referred to as incarcerated individual 10.

¹⁶ CBO Policy #9.30 states, "GENERAL POPULATION, ICP, IICP, Tr-ICP, BHU, TBU, RMHU, and CORP: MHS 1 and all S designated: monthly."

¹⁷ CBO Policy #9.27 Psychiatric Progress Notes states, "General Population (GP) and all other locations except RCTP, SHU, LTKL, and Reception Units: Must be completed within one month of admission to services on Level 1-3 patients."

¹⁸ September 16, 2021 Psychiatric Progress Note

¹⁹ September 28, 2021 Psychiatric Progress Note

incarcerated individual in recognizing the link between their behaviors and potential consequences, but they also encourage positive behavior and motivate individuals to earn incentives and be recognized for their positive behavior. Positive reinforcement increases the likelihood that the behavior is more likely to occur in the future.

2. Please provide information and/or documentation demonstrating when these individuals were removed from Exceptional Circumstances.
3. Time frames for mental health evaluations and assessments should be strictly adhered to so that incarcerated individuals receive services in a timely manner during incarceration. The Justice Center recommends that more Video Tele Conferencing (VTC) sessions be scheduled to accommodate individuals who do not attend their call outs for one reason or another. The Justice Center also encourages mental health and psychiatric staff to encourage the importance of mental health call outs and how this will benefit their mental health. Please provide documentation demonstrating the above listed incarcerated individuals were assessed by psychiatric staff according to policy. If there is no documentation demonstrating they were assessed by psychiatric staff, please ensure that the appropriate staff are re-trained on CBO Policy #2.4 Cancelled/Missed/Refused Call Outs and provide documentation they have been re-trained.

A six-month review of DOCCS and OMH records often includes records of treatment that an incarcerated individual received at another correctional facility before being transferred to the correctional facility reviewed. The recommendations below do not pertain to the Five Points CF RMHU:

4. Psychiatric and mental health callouts are imperative to an incarcerated individual's well-being, and it is DOCCS responsibility to ensure that every effort is made to keep these appointments. Please provide an explanation as to why [REDACTED] was not escorted to their mental health call out on August 31, 2021 at the Auburn CF.
5. Please provide documentation demonstrating Incarcerated Individual 6 was assessed by mental health staff at the Great Meadow CF according to policy. If there is no documentation demonstrating they were assessed by mental health staff, please ensure that the appropriate staff at the Great Meadow CF are re-trained on CBO Policy #9.30 Progress Notes and provide documentation they have been re-trained.
6. Please provide documentation demonstrating Incarcerated Individual 5 was assessed by mental health staff at the Walsh RMU according to policy. If there is no documentation demonstrating they were assessed by mental health staff, please ensure that the appropriate staff at the Walsh RMU are re-trained on CBO Policy #2.4 Cancelled/Missed/Refused Call Outs and provide documentation they have been re-trained.
7. Please provide documentation demonstrating Incarcerated Individual 1 was assessed by mental health staff at the Attica CF TrICP according to policy. If there is no documentation demonstrating they were assessed by mental health staff, please ensure

that the appropriate staff at the Attica CF are re-trained on CBO Policy #9.30 Progress Notes and provide documentation they have been re-trained.

8. Per documentation received by the Justice Center, Incarcerated Individual 1 and Incarcerated Individual 9 were not assessed by mental health staff according to guidelines delineated in the SHU Exclusion Law while at the Attica CF. Please provide documentation demonstrating they were assessed according to the guidelines. If there is no documentation demonstrating they were assessed by mental health staff according to the guidelines, please ensure the appropriate staff at the Attica CF are re-trained in the importance of the guidelines in the SHU Exclusion Law and that assessments are both necessary and required.
9. Accurate documentation is a critical component in an incarcerated individual's continuity of care. To ensure the integrity of documentation and adequate mental health care and treatment, it is important that mental health staff record accurate and updated information. Please explain the discrepancies between the Psychiatric Progress Note and Physician's Orders for Incarcerated Individual 10. If OMH agrees with the Justice Center's findings of discrepancies between the two documents, please re-train the appropriate staff at the Elmira CF on CBO Policy #9.27 Psychiatric Progress Notes and CBO Policy #9.33 Physician's Orders.

Review conducted by: 
Angelina LoCascio, Facility Review Specialist



Corrections and Community Supervision

KATHY HOCHUL
Governor

ANTHONY J. ANNUCCI
Acting Commissioner

June 30, 2022

Davin Robinson
Deputy Director, Office of Outreach, Prevention & Support
NYS Justice Center for the Protection
of People with Special Needs
161 Delaware Avenue
Delmar, NY 12054

Re: [REDACTED] Justice Center Oversight Action

Dear Ms. Robinson:

This is in response to the New York State Justice Center's review of the Residential Mental Health Unit (RMHU) on the quality of mental health care provided for incarcerated individuals as well as compliance with the SHU Exclusion Law for the site visit conduct on November 10, 2021 at Five Points Correctional Facility.

Recommendation: The Justice Center commends the Five Points CF RMHU for issuing positive Informational Reports. Informational Reports are important because they assist the incarcerated individual in recognizing the link between their behaviors and potential consequences, but they also encourage positive behavior and motivate individuals to earn incentives and be recognized for their positive behavior. Positive reinforcement increases the likelihood that the behavior is more likely to occur in the future.

Response: I appreciate the acknowledgement in your report on the hard work and clear understanding that the staff at Five Points CF has for the benefit of utilizing informational reports.

Recommendation: Please provide information and/or documentation demonstrating when these individuals were removed from Exceptional Circumstances.

Response: In following up, there were clear issues with proper documentation on the Exceptional Circumstance documentation mainly with not completing the end dates of the exceptional circumstance. I attached the treatment team meeting minutes showing that one incarcerated individual was removed from exceptional circumstance. In addition, attached is the razor deprivation order for incarcerated individual 2 with the end date. For incarcerated individual 3, the exceptional circumstance for razor on October 20, 2021 did not show end date, but the facility did track on their daily report for the removal on October 28th. Despite having documentation for exceptional circumstances in meeting minutes and on their daily report the importance and accuracy of proper documentation on the exceptional circumstance forms must be completed. Deputy Superintendent Miller did address in a memo (attached) and will be address with supervisors.

Recommendation: Psychiatric and mental health callouts are imperative to an incarcerated individual's well-being, and it is DOCCS responsibility to ensure that every effort is made to keep these appointments. Please provide an explanation as to why [REDACTED] was not escorted to their mental health call out on August 31, 2021 at the Auburn CF.

Response: Upon investigation into the mandatory mental health call-out for the incarcerated individual at Auburn CF, there was an assault on staff that resulted in an officer being cut in the face and movement had been placed on hold. Office of Mental Health was notified of the incident and advised to reschedule the appointment.

Thank you for your oversight services because this helps improve our Department. I look forward to continuing working productively with the Justice Center to improve the services for our population.

Sincerely,

A handwritten signature in black ink, appearing to read "B. Hilton", followed by a horizontal line.

Bryan Hilton
Associate Commissioner

cc: Amy Lamanna, Superintendent – Five Points Correctional Facility
Angelina LoCascio, Facility Review Specialist, Justice Center

KATHY HOCHUL
Governor

ANN MARIE T. SULLIVAN, M.D.
Commissioner

MOIRA TASHJIAN, MPA
Executive Deputy Commissioner

July 21, 2022

Davin Robinson
Deputy Director of Outreach, Prevention and Support
Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, New York 12054

Dear Ms. Robinson:

We received your letter dated June 17, 2022, in response to the Justice Center's November 10, 2021 site visit of the Five Points Residential Mental Health Unit (RMHU) 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. Please note that the documentation includes protected health information and thus should not be redisclosed.

Recommendation #1:

"The Justice Center commends the Five Points CF RMHU for issuing positive Informational Reports. Informational Reports are important because they assist the incarcerated individual in recognizing the link between their behaviors and potential consequences, but they also encourage positive behavior and motivate individuals to earn incentives and be recognized for their positive behavior. Positive reinforcement increases the likelihood that the behavior is more likely to occur in the future."

OMH Response:

The Justice Center's commendation was shared with OMH staff at Five Points RMHU, and they will continue to utilize positive informationals.

Recommendation #2:

"Please provide information and/or documentation demonstrating when these individuals were removed from Exceptional Circumstances."

OMH Response:

OMH defers to DOCCS regarding this recommendation, as they are responsible for maintaining Exceptional Circumstances documentation.

Recommendation #3:

"Time frames for mental health evaluations and assessments should be strictly adhered to so that incarcerated individuals receive services in a timely manner during incarceration. The Justice Center recommends that more Video Tele Conferencing (VTC) sessions be scheduled to

accommodate individuals who do not attend their call outs for one reason or another. The Justice Center also encourages mental health and psychiatric staff to encourage the importance of mental health call outs and how this will benefit their mental health. Please provide documentation demonstrating the above listed incarcerated individuals were assessed by psychiatric staff according to policy. If there is no documentation demonstrating they were assessed by psychiatric staff, please ensure that the appropriate staff are re-trained on CBO Policy #2.4 Cancelled/Missed/Refused Call Outs and provide documentation they have been re-trained."

OMH Response:

OMH staff understand the importance of mental health call outs and routinely encourage attendance at call outs. All individuals cited by the Justice Center were already scheduled with a prescriber more frequently than required per policy due to their continued refusals and/or were assessed cellside by clinicians after their second refusal, per policy. Despite this, the Justice Center has recommended that psychiatric staff schedule more sessions to be even more accommodating. OMH prescribers, both onsite and via VTC, are scheduled to the extent possible. The VTC prescribers cover multiple facilities and therefore can have over 200 individuals on their caseload. On a daily basis, scheduling for OMH prescribers must account for emergencies, other missed appointments, other clinical responsibilities, and equipment issues. It should be noted that missed appointments are a problem common to all clinic settings, including those in the community, and impacts both medical and mental health clinics.

Information on the individual cases is as follows:

- Incarcerated individual 4: He accepted his private psychiatric interview on 11/23/21 (note enclosed).
- Incarcerated individual 5: He refused another psychiatric callout on 12/16/21 but attended his 1/5/22 psychiatric appointment (note enclosed).
- Incarcerated individual 6: He refused another psychiatric callout on 11/23/21 but attended his 11/30/21 psychiatric appointment (note enclosed).
- Incarcerated individual 7: As indicated by the Justice Center, he accepted his 10/19/21 psychiatric appointment.
- Incarcerated individual 8: He continued to refuse or miss psychiatric appointments offered to him on 11/16/21, 11/30/21, 12/14/21, 1/11/22, 1/25/22, 2/8/22, 2/15/22, and 3/1/22. He accepted his 3/16/22 psychiatric appointment (note enclosed).

Recommendation #4:

"Psychiatric and mental health callouts are imperative to an incarcerated individual's well-being, and it is DOCCS responsibility to ensure that every effort is made to keep these appointments. Please provide an explanation as to why [REDACTED] was not escorted to their mental health call out on August 31, 2021 at the Auburn CF."

OMH response not indicated, as recommendation is directed to DOCCS.

Recommendation #5:

"Please provide documentation demonstrating Incarcerated Individual 6 was assessed by mental health staff at the Great Meadow CF according to policy. If there is no documentation demonstrating they were assessed by mental health staff, please ensure that the appropriate staff at the Great Meadow CF are re-trained on CBO Policy #9.30 Progress Notes and provide documentation they have been re-trained."

OMH Response:

Documentation is enclosed showing incarcerated individual 6 was seen on 6/3/21, 6/30/21, and 7/30/21.

Recommendation #6:

"Please provide documentation demonstrating Incarcerated Individual 5 was assessed by mental health staff at the Walsh RMU according to policy. If there is no documentation demonstrating they were assessed by mental health staff, please ensure that the appropriate staff at the Walsh RMU are re-trained on CBO Policy #2.4 Cancelled/Missed/Refused Call Outs and provide documentation they have been re-trained."

OMH Response:

The Walsh RMU clinician indicated that the 8/3/21 contact occurred cellside, thus satisfying the requirement in CNYPC CBO Policy #2.4. However, as that was not clearly stated in the corresponding progress note, the clinician has been reminded of the importance of documenting the location and type of contact in all progress notes. A formal retraining of policy was not indicated.

Recommendation #7:

"Please provide documentation demonstrating Incarcerated Individual 1 was assessed by mental health staff at the Attica CF TrICP according to policy. If there is no documentation demonstrating they were assessed by mental health staff, please ensure that the appropriate staff at the Attica CF are re-trained on CBO Policy #9.30 Progress Notes and provide documentation they have been re-trained."

OMH Response:

Per OMH's internal database, incarcerated individual 1 was scheduled for an appointment on 6/21/21, which he missed. The clinician did not write a note for the missed appointment per CNYPC CBO Policy #2.4 Cancelled/Refused/Missed Callouts. However, as she no longer works for CNYPC, policy could not be reviewed.

Recommendation #8:

"Per documentation received by the Justice Center, Incarcerated Individual 1 and Incarcerated Individual 9 were not assessed by mental health staff according to guidelines delineated in the SHU Exclusion Law while at the Attica CF. Please provide documentation demonstrating they were assessed according to the guidelines. If there is no documentation demonstrating they were assessed by mental health staff according to the guidelines, please ensure the appropriate staff at the Attica CF are re-trained in the importance of the guidelines in the SHU Exclusion Law and that assessments are both necessary and required."

OMH Response:

Documentation is enclosed showing incarcerated individual 1 received his 14-day SHU assessment on 7/30/21 per policy. Documentation is also enclosed showing incarcerated individual 9 could not attend his 8/30/21 intake SHU evaluation and was seen the next day; and that he had another SHU intake evaluation on 9/16/21 upon his discharge from the RCTP.

Recommendation #9:

"Accurate documentation is a critical component in an incarcerated individual's continuity of care. To ensure the integrity of documentation and adequate mental health care and treatment, it is important that mental health staff record accurate and updated information. Please explain the discrepancies between the Psychiatric Progress Note and Physician's Orders for Incarcerated

Individual 10. If OMH agrees with the Justice Center's findings of discrepancies between the two documents, please re-train the appropriate staff at the Elmira CF on CBO Policy #9.27 Psychiatric Progress Notes and CBO Policy #9.33 Physician's Orders."

OMH Response:

It was determined that the prescriber intended to order [REDACTED]. The CBO Clinical Director reviewed with this prescriber the importance of ensuring that the dosage ultimately ordered via the Physician's Orders is accurately reflected in the corresponding progress note.

Of note, the Justice Center cited that incarcerated individual 10 was not assessed by mental health staff in June-September 2021; however, documentation showing otherwise is enclosed with this response.

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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