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

**ANDREW M. CUOMO**
Governor

**DENISE M. MIRANDA**
Executive Director

July 8, 2020

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 conduct quality of mental health care reviews and 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 25-26, 2020, the Justice Center's Forensic Unit conducted a site visit to the Great Meadow Correctional Facility's Special Housing Unit (SHU) 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 August 10, 2020. 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
Kathryn Farley, Facility Review Specialist, Forensics
Dr. Anne Sullivan, M.D., Commissioner, OMH
Danielle Dill, Acting Executive Director, CNYPC
William Vertoske, Forensic Services Program Administrator 2, OMH
Laurie Turnbull, 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.

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

**ANDREW M. CUOMO**
Governor

**DENISE M. MIRANDA**
Executive Director

**Review of Justice Center Oversight Action**
**Great Meadow Correctional Facility – Special Housing Unit (SHU) Compliance/**
**Quality of Care**
**JC#:** [redacted]

On February 25-26, 2020, the Justice Center for the Protection of People with Special Needs (the Justice Center) conducted a site visit at the Great Meadow Correctional Facility (CF) to review the quality of mental health care provided to inmates, and determine compliance with the SHU Exclusion Law, Office of Mental Health (OMH) policies, and Department of Corrections and Community Supervision (DOCCS) directives.[1] The census of the SHU at the time of the visit was 71 inmates and 50 were on the mental health caseload. There were 3 inmate/patients in the Great Meadow CF SHU that met the SHU Exclusion Law criteria for the definition of serious mental illness during our site visit.

In addition to reviewing the OMH clinical case record, DOCCS SHU folders, and the DOCCS guidance records, Justice Center staff members also requested any exceptional circumstances documentation for the current census for a time-period of six months.

**Compliance Determination:**

To assess compliance, the Forensic Unit toured the SHU and spoke cell-side with 68 individuals.[2] We also reviewed the records of 36 inmates and/or patients 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.
[2] 3 inmates were unavailable for cell side interviews while the Justice Center was on site.

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 no inmate/patients placed on exceptional circumstances during the review period. Based upon our review, the Justice Center has made a determination that the Great Meadow CF 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 SHU. In an effort to complete a thorough evaluation, Justice Center staff requested private interviews and 10 individuals chose to speak with the Justice Center. The Justice Center also examined clinical documentation, DOCCS SHU folders, Guidance Records, and reviewed the DOCCS Sign-In Logbook and Unit Activity Logbook. The findings from this review are outlined below.

**Justice Center Findings**

1. **Three inmate/patients were designated Mental Health Service Level (MHSL) 1S in the Great Meadow CF SHU during the Justice Center's site visit.**

   - Inmate/patient [redacted] (DIN: [redacted]), a MHSL 1SV, was admitted to the SHU on February 7, 2019. At the time of the Justice Center's visit, his disciplinary hearing was pending.

   - Inmate/patient [redacted] (DIN:[redacted]), was admitted to the SHU on February 24, 2020. At the time of the Justice Center's visit, his disciplinary hearing was pending.

   - Inmate/patient [redacted] (DIN:[redacted]) was admitted to the SHU on February 20, 2020. At the time of the Justice Center's visit, his disciplinary hearing was pending. [redacted] DOCCS Chronological Record indicates that he was transferred to the Marcy CF Residential Mental Health Unit (RMHU) on March 2, 2020.

2. **Inmate/patient [redacted] (DIN: [redacted]) reported that he attended mental health callouts and was sent back to his housing unit without being seen.**

   [redacted] was transferred to the Great Meadow CF from the Coxsackie CF Residential Mental Health Unit (RMHU) on November 12, 2019. According to progress notes, he did not show for his subsequent mental health callouts on November 27, 2019 and December 31, 2019. Per a progress note, [redacted] was next seen on January 9, 2020 where, "Pt. reported having attended callouts but had been sent back without being seen." [3]

3. **Inmate/patient [redacted] (DIN:[redacted]) missed his scheduled psychiatric callouts and they were not rescheduled per CNYPC CBO Policy #2.4.[4]**

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[3] Primary Therapist Progress Note dated January 9, 2020

[4] CNYPC CBO Policy #2.4- Canceled/Refused/Missed Callouts, 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 cell-side visit with the inmate-patient within three (3) business days of the missed rescheduled callout."

On January 22, 2020, [redacted], a MHSL 1S, did not show for his psychiatric callout. He was previously seen by psychiatric staff on October 23, 2019. According to documentation received by the Justice Center, his missed callout was not rescheduled.

4. **Two inmate/patients were not seen by a primary therapist per CNYPC CBO Policy #9.30.[5]**

   - Inmate/patient [redacted] (DIN: [redacted]), a MHSL 1S, was seen by his primary therapist on October 18, 2019. On November 5, 2019, [redacted] was transferred to the Auburn CF on out to court status. He returned to Great Meadow CF on November 18, 2019 before being transferred out again on December 10, 2019. Per documentation received by the Justice Center, [redacted] was not seen by mental health staff within two weeks of his transfer back to the Great Meadow CF on November 18, 2019. [redacted] received his next clinical contact on December 20, 2019.[6]

   - Inmate/Patient [redacted] (DIN[redacted] a MHSL 2, was seen by his primary therapist on December 18, 2019. It does not appear that he was seen again by mental health staff until February 18, 2020 when he was seen for an intake SHU/LTKL Mental Health Assessment.

5. **The Chronological Record of two inmate/patients were not completed per CNYPC CBO Policy #9.7.[7]**

   On May 17, 2019, [redacted] (DIN: [redacted]) MHSL was changed from a 3 to a 2, however, this update was not reflected in his Chronological Record.[8] Per documentation received by the Justice Center, [redacted] Chronological Record has not been updated since June 25, 2019.

   [redacted] (DIN: [redacted]), a MHSL 1S, returned to the Great Meadow CF on December 23, 2019 after four different out to court transfers (OTC) to Auburn CF.[9] [redacted] Chronological Record was not updated regarding his return.

6. **Inmate/patient's Chronological were not completed per CNYPC CBO Policy #9.7 at the Five Points CF and the Upstate CF.[10]**

   - [redacted] (DIN: [redacted]) was admitted to the Residential Crisis Treatment Program (RCTP) on August 11, 2019 for threats of self-harm. [redacted] admission and discharge to the RCTP are not reflected on his Chronological Record.

   - On October 16, 2019, [redacted] (DIN: [redacted]), a MHSL 3, was out of the facility on a trip and returned on October 23, 2019.[11] [12] [redacted] trip was not documented on his Chronological Record.

7. **Inmate/patient [redacted] (DIN: [redacted]) did not have a DOCCS Suicide Prevention Screening Guideline #3152 completed upon his admission to the Mid-State CF SHU.**

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[5] CBO Policy #9.30- Progress Notes, states, "Within 2 weeks of transfer* into Level 1 and 2 facilities for active patients with a mental health level of I, II, or III. Monthly thereafter."
[6] Termination Transfer Progress Note dated December 20, 2019
[7] CNYPC CBO Policy #9.7 – Chronological Record states it "is utilized to provide Unit staff with ready access to all transactions that occur in the patient's record."
[8] Treatment Needs/Service Level Designation dated May 17, 2019
[9] Termination Transfer Progress Note dated December 20, 2019
[10] CNYPC CBO Policy #9.7 – Chronological Record states it "is utilized to provide Unit staff with ready access to all transactions that occur in the patient's record."
[11] Psychiatric Progress Note dated October 16, 2019
[12] SHU/LTKL Mental Health Interview dated October 23, 2019

[redacted], a Mental Health Service Level (MHSL) 3, was admitted to the SHU from observation on August 26, 2019. Per a SHU/LTKL Mental Health Interview, [redacted] had, "No #3152." [13]

**Justice Center Findings**

1. The Justice Center requests an update from DOCCS regarding [redacted] and [redacted] status and their diversion to a Residential Mental Health Unit (RMHU), if warranted. Please provide confirming documentation to the Justice Center regarding [redacted] transfer to the Marcy CF RMHU. In addition, please forward documentation regarding the conclusion of the three inmates/patients' disciplinary hearings and transfer dates if applicable.

2. The Justice Center requests clarification from both DOCCS and OMH as to why [redacted] was returned to his housing unit from his mental health callouts without being seen on November 27, 2019 and December 31, 2019.

3. Inmate/patients should be seen by psychiatric staff regularly to ensure they are receiving adequate mental health care. If an inmate/patient misses a psychiatric appointment for any reason, OMH should immediately reschedule them per policy. OMH Staff should be retrained on CNYPC CBO Policy #2.4- Canceled/Refused/Missed Callouts. The OMH Unit Chief should also complete quality assurance checks to ensure the policy is being followed.

4. For inmates/patients to be appropriately evaluated and assessed, time frames must be taken seriously and documented appropriately especially in relation to transfers. Due to the amount of movement within the DOCCS system, it is especially imperative to meet with inmates quickly and assess their mental status as these moves can be stressful. OMH Staff should be retrained in CBO CNYPC Policy #9.30-Progress Notes to ensure that inmate/patients are being seen within the appropriate time frames.

5. Accurate documentation is a critical aspect in an inmate/patient'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 in an inmate/patient record. Staff should be retrained in CNYPC CBO Policy #9.7- Chronological Record and the Unit Chief should do regular quality assurance checks.

6. The Justice Center requests that the Five Points and Upstate CF's Unit Chiefs complete quality assurance checks to ensure the Chronological Records are updated appropriately. In addition, staff at both facilities should be retrained in CNYPC CBO Policy #9.7- Chronological Record.

7. The Justice Center requests that DOCCS staff at the Mid-State CF SHU be retrained in DOCCS Directive #4101-Suicide Prevention to ensure that the Suicide Prevention Screening Guidelines #3152 is completed upon admission to the SHU. If there was a #3152 completed upon [redacted] admission, please include it with your response

[13] SHU/LTKL Mental Health Interview dated August 27,2019

Review conducted by: _____

Kathryn Farley, Facility Review Specialist

NEW YORK STATE | Corrections and Community Supervision

**ANDREW M. CUOMO**
Governor

**ANTHONY J. ANNUCCI**
Acting Commissioner

July 9, 2020

Denise M. Miranda, Esq.
Executive Director
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. Miranda:

This is in response to the New York State Justice Center's report of the site visit conducted at Great Meadow Correctional Facility on February 25-26, 2020 ensuring the quality of corrections-based mental health care for incarcerated individuals and compliance with the SHU Exclusion Law compliance.

**Recommendations:**

1. The Justice Center requests an update from DOCCS regarding incarcerated individual [redacted] and [redacted] status and their diversion to a Residential Mental Health Unit (RMHU). Provide confirming documentation to the Justice Center regarding to incarcerated individual [redacted] transfer to Marcy RMHU. In addition, please forward documentation regarding the conclusion of the three incarcerated individuals' disciplinary hearings and transfer dates if applicable.

**Response:**

[redacted], transferred to Coxsackie RMHU on February 26, 2020.

[redacted], transferred to Coxsackie RMHU on March 16, 2020.

[redacted], transferred to Marcy RMHU on March 3, 2020.

2. The Justice Center requests clarification from both DOCCS and OMH as to why incarcerated individual [redacted] was returned to his housing unit from his mental health call-outs without being seen on November 27, 2019 and December 31, 2019.

Response:
In following up on incarcerated individual [redacted], the activity logbook does document he went to his call-out with OMH. Per OMH, they do not have documentation for the reason he did not show. This is currently being investigated further. Once the investigation is completed will take the necessary action to ensure that proper documentation is recorded and ensure location of all inmates.

7. The Justice Center requests that DOCCS staff at Midstate CF SHU be trained in DOCCS Directive #4101- Suicide Prevention Screening Guidelines #3152, is completed upon admission to SHU.

Response:

The security supervisor must complete the 3152 "Suicide Prevention Screening Guidelines" upon return from the infirmary or outside hospital. In addition, the memo clarifying procedures on 3152 "Suicide Screening Guidelines" was sent out to the facility. In addition, all security supervisors will be retrained at Midstate Cf. The Deputy Superintendent for Security has been notified and will provide the training completion form once received.

Thank you for the opportunity to comment on your report. I look forward to continuing working productively with the Justice Center to improve the services for our population.

Sincerely,

Bryan Hilton
Associate Commissioner

cc: Christopher Miller, Superintendent – Great Meadow Correctional Facility
Kathryn Farley, Facility Review Specialist

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

July 28, 2020

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 July 8, 2020 in response to the Justice Center's recent site visit to the Great Meadow Correctional Facility (CF) Special Housing Unit (SHU) to determine the quality of mental health care provided to inmate-patients, and determine compliance with the 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:**
"The Justice Center requests an update from DOCCS regarding [redacted] and [redacted] status and their diversion to a Residential Mental Health Unit (RMHU), if warranted. Please provide confirming documentation to the Justice Center regarding [redacted] transfer to the Marcy CF RMHU. In addition, please forward documentation regarding the conclusion of the three inmates/patients' disciplinary hearings and transfer dates if applicable."

**OMH Response:**
OMH defers to DOCCS regarding this recommendation.

**Recommendation #2:**
"The Justice Center requests clarification from both DOCCS and OMH as to why [redacted] was returned to his housing unit from his mental health callouts without being seen on November 27, 2019 and December 31, 2019."

**OMH Response:**
Given the time that has passed since this occurred, OMH is unable to thoroughly investigate the circumstances and determine whether this was an OMH issue. Nonetheless, the Great Meadow Unit Chief has reviewed CNYPC CBO Policy #2.4 Canceled/Refused//Missed Callouts, and the importance of reporting issues seeing inmate/patients for callouts to the Unit Chief, with clinical staff.

**Recommendation #3:**
"Inmate/patients should be seen by psychiatric staff regularly to ensure they are receiving adequate mental health care. If an inmate/patient misses a psychiatric appointment for any

reason, OMH should immediately reschedule them per policy. OMH Staff should be retrained on CNYPC CBO Policy #2.4- Canceled/Refused/Missed Callouts. The OMH Unit Chief should also complete quality assurance checks to ensure the policy is being followed."

**OMH Response:**
CNYPC CBO Policy #2.4 Canceled/Refused//Missed Callouts was reviewed with the staff responsible for scheduling psychiatric callouts at Great Meadow CF.

**Recommendation #4:**
"For inmates/patients to be appropriately evaluated and assessed, time frames must be taken seriously and documented appropriately especially in relation to transfers. Due to the amount of movement within the DOCCS system, it is especially imperative to meet with inmates quickly and assess their mental status as these moves can be stressful. OMH Staff should be retrained in CBO CNYPC Policy #9.30-Progress Notes to ensure that inmate/patients are being seen within the appropriate time frames."

**OMH Response:**
Upon review, it was found that [redacted] was scheduled for a callout on 11/27/19 after his return from court, which is sooner than required per policy. However, he missed this appointment and went back out to court on 12/10/19. Clinical staff were reminded that they need to complete progress notes for missed callouts in accordance with CNYPC CBO Policy #2.4 Canceled/Refused/Missed Callouts. The clinician responsible for assessing [redacted] no longer works for CNYPC, therefore policy could not be reviewed with her.

**Recommendation #5:**
"Accurate documentation is a critical aspect in an inmate/patient'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 in an inmate/patient record. Staff should be retrained in CNYPC CBO Policy #9.7- Chronological Record and the Unit Chief should do regular quality assurance checks."

**OMH Response:**
Regarding [redacted], the Regional FPA reviewed CNYPC CBO Policy #9.7 Chronological Record with the Upstate Unit Chief who was responsible for updating the Chronological Record in this case. However, OMH would like to highlight that this information was appropriately documented on the May 17, 2019 Treatment Needs/Service Level Designation form.

Regarding [redacted], the Great Meadow Unit Chief reviewed CNYPC CBO Policy #9.7 Chronological Record with all OMH staff. However, OMH would like to highlight that this information was appropriately documented on the December 20, 2019 Termination/Transfer Progress Note.

**Recommendation #6:**
"The Justice Center requests that the Five Points and Upstate CF's Unit Chiefs complete quality assurance checks to ensure the Chronological Records are updated appropriately. In addition, staff at both facilities should be retrained in CNYPC CBO Policy #9.7- Chronological Record."

**OMH Response:**
Five Points and Upstate Unit Chiefs reviewed CNYPC CBO Policy #9.7 Chronological Record with the staff responsible for updating Chronological Records at their respective units. Unit Chiefs will also conduct quality assurance checks to ensure chart documentation is updated per policy.

**Recommendation #7:**
"The Justice Center requests that DOCCS staff at the Mid-State CF SHU be retrained in DOCCS Directive #4101-Suicide Prevention to ensure that the Suicide Prevention Screening Guidelines #3152 is completed upon admission to the SHU. If there was a #3152 completed upon [redacted] admission, please include it with your response."

**OMH Response:**
OMH defers to DOCCS regarding this recommendation.

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., Acting Executive Director, CNYPC
William Vertoske, Associate Director, Corrections Based Operations, CNYPC
File