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Justice Center for the Protection of People with Special Needs

SHU Exclusion Monitoring Report

4th Quarter 2019

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Introduction
Executive Law §553, charged the New York State Justice Center for the Protection of People with Special Needs (Justice Center) with the responsibility to oversee compliance with the Special Housing Unit (SHU) Exclusion Law. This includes the responsibility to monitor and make recommendations regarding the quality of care provided to inmates with serious mental illness, including those who are in a residential mental health treatment unit or segregated confinement in facilities operated by the New York State Department of Corrections and Community Supervision (DOCCS).[1] In order to carry out this responsibility, the Justice Center visits the SHU units in prisons to review compliance and conducts systemic reviews of mental health programs in state-operated correctional facilities.

Report: Fourth Quarter of 2019 (October-December)
The Justice Center initiated eight SHU Compliance/Quality of Mental Health Care Reviews in the fourth quarter of 2019; completing 127 cell-side interviews, 22 private interviews, 101 compliance reviews, and 101 reviews of the quality of mental health care provided (QMHC).

Quarterly Summary: Fourth Quarter of 2019 Correctional Facility Date of Visit	***Inmates interviewed cell-side by Justice Center***	***Private Interviews Accepted***	***Inmates referred for immediate action***	***SHU Compliance Reviews Completed***	***Quality of Mental Health Reviews Completed***
Shawangunk CF - 10/15/2019	9	2	0	9	9
Eastern CF – 10/16/2019	14	3	3	14	14
Washington CF – 10/24/2019	26	2	5	19	19
Downstate CF – 11/5/2019	11	3	0	11	11
Wende CF – 11/19/2019	17	4	6	17	17
Groveland CF – 11/20/2019	19	3	5	13	13
Woodbourne CF – 12/10/2019	4	1	2	2	2
Marcy CF – 12/19/2019	27	4	4	16	16
Totals	**127**	**22**	**25**	**101**	**101**

[1] NYS Correction Law Section 401 (a)

Inmates Interviewed by the Justice Center: Whenever possible, every inmate in the SHU is interviewed cell-side by Justice Center staff. Numbers of cell-side interviews reflect the census of inmates in the SHU at the time of the Justice Center's visit for the Shawangunk CF, Eastern CF, Downstate CF, and Wende CF. However, the census for the Washington CF, Groveland CF, Woodbourne CF and Marcy CF was higher than the number of cell-side interviews conducted by the Justice Center.

Private Interviews Accepted: During cell-side interviews, inmates are offered an opportunity to meet with Justice Center staff. Those that agree are interviewed privately.

Inmates Referred to OMH For Immediate Action: Based on requests from inmates, or observations by Justice Center staff, names of inmates and of the immediate concern observed by Justice Center staff, are provided to the OMH Unit Chief for referral. Issues related to medication are referred for review by a psychiatrist. Others are referred to OMH for review by a clinician.

SHU Compliance Reviews: Number of inmate and/or patient records reviewed for compliance with timeframes contained in the SHU Exclusion Law.[2]

Quality Reviews Completed: Number of inmate and/or patient records reviewed for quality of mental health care provided. Specifically, Justice Center reviews whether care is in accordance with OMH Policies and Procedures and DOCCS Directives.

SHU Compliance Findings Summary of all eight Correctional Facilities:

All eight facilities visited by the Justice Center were in compliance with the timeframes contained in the SHU Exclusion Law. In the facilities reviewed by the Justice Center, there were two inmate-patients at one facility who met the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the fourth quarter of 2019.

Quality of Mental Health Care (QMHC) Findings Summary of Issues Found at More than One Correctional Facility:

- Inmate-patients not seen monthly or upon transfer by their primary therapist as required by OMH policy. (Four facilities)
- Inmate-patients did not have the opportunity to speak with psychiatric staff as required by OMH policy. (Two facilities)

SHU Compliance Findings at Individual Correctional Facilities:

Shawangunk CF

Visit Overview: Visited facility on October 15, 2019; nine cell-side interviews conducted with two private interviews accepted; no inmates were referred to a mental health clinician; and nine records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

[2] NYS Correction Law, Section 137 (d) and (e)

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC: There were nine records reviewed for quality of mental health care and there were no issues of concern related to the quality of mental health care provided.

Eastern CF

Visit Overview: Visited facility on October 16, 2019; 14 cell-side interviews were conducted with three private interviews accepted; three inmates and/or patients were referred to a mental health clinician; and 14 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: 14 records were reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

The Justice Center determined that an inmate-patient did not have the opportunity to speak with psychiatric staff. It was documented in their clinical case record that a security escort was not available to facilitate an appointment with OMH staff due to hearings in process. The Justice Center requested that the DOCCS Executive Team consider retraining security staff on the importance of private mental health call outs, specifically ensuring that escorts are available. OMH deferred to DOCCS regarding this recommendation. DOCCS indicated that retraining was not necessary as a hearing had run over, therefore security staff was unavailable. They further noted that the inmate in question was rescheduled and seen by OMH two days later.

Two inmates were referred to Alcohol and Substance Abuse Treatment (ASAT) and Aggression Replacement Training (ART) while in the SHU. An update was requested regarding their program placement. OMH deferred to DOCCS regarding this request. DOCCS reported that the first inmate did not meet the criteria to complete the ASAT program because of no documented history of substance abuse. The second inmate was placed on the waiting list of both programs, ASAT and ART.

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

Upon the Justice Center's review of an inmate-patient's clinical case record, progress notes were found to be repetitive and did not provide any insight to the inmate-patient's current mental health treatment. The Justice Center requested that the Unit Chief complete a review of the inmate-patient's clinical case record to ensure that mental health concerns are documented appropriately. In addition, the Justice Center recommended that OMH staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes and stress that notes are written in real time and reflect current mental health status. OMH provided course enrollment forms that the inmate-patient's primary therapist at the Elmira CF was retrained in CNYPC CBO Policy #9.30 –

Progress Notes, with a focus on ensuring progress notes are written with individualized mental health status exams, group topics and how the inmate-patient is progressing in treatment.

There was an inmate-patient that did not have the opportunity to meet with mental health staff in accordance with OMH policy at the Elmira CF after they missed a private call out and were not rescheduled on a timely basis. OMH staff were asked to retrain in both CNYPC CBO Policy #9.30 – Progress Notes and # 2.4 – Canceled/Refused/Missed call outs. In addition, the Justice Center recommended that the Unit Chief complete quality assurance checks to ensure that inmate-patients are monitored in the appropriate timeframes. OMH provided documentation the staff were retrained in both policies as requested.

Washington CF

Visit Overview: Visited facility on October 24, 2019; 26 cell-side interviews were conducted with two private interviews accepted; five inmates and/or patients were referred to a mental health clinician; and 19 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: There were 19 records reviewed for quality of mental health care and there were no issues of concern related to the quality of mental health care provided.

Downstate CF

Visit Overview: Visited facility on November 5, 2019; 11 cell-side interviews conducted with three private interviews accepted; no inmate and/or patients were referred to a mental health clinician; and 11 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: There were 11 records reviewed for quality of mental health care and there were no issues of concern related to the quality of mental health care provided.

Wende CF

Visit Overview: Visit conducted on November 19, 2019; 17 cell-side interviews conducted with four private interviews accepted; six inmate-patients were referred to a mental health clinician; 17 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were two inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: 17 records were reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

The Justice Center found that two inmate-patients were MHSL 1S and pending their disciplinary hearing at the time of the site visit. An update was requested regarding their diversion to a Residential Mental Health Treatment Unit. OMH deferred to DOCCS in their response. DOCCS provided an update that both inmate-patients were transferred appropriately at the conclusion of their disciplinary hearing

The Justice Center determined that an inmate-patient did not have the opportunity to speak with psychiatric staff on two occasions due to Keep Lock status and no security escort being available. The Justice Center requested an explanation as to why the inmate-patient was not afforded the chance to attend the call outs. OMH deferred to DOCCS regarding this recommendation. DOCCS indicated that all security supervisors provided direction that all incarcerated individuals on keep lock status will be escorted to their mental health callouts.

A review of the clinical case records found that two inmate-patients were not seen by mental health staff in accordance with CNYPC CBO policy. Neither inmate-patient was seen by mental health staff in September and October 2019. To confirm that inmate-patients are seen in the appropriate time frame and documentation complete, the Justice Center recommended that OMH retrain all clinical mental health staff in CNYPC CBO Policy #9.30 – Progress Notes. The Justice Center also recommended that the Unit Chief complete quality assurance checks to ensure that inmate-patients are monitored in the appropriate timeframes. The Justice Center also requested whether there was an existing policy for caseload coverage in the event of mental health staff absences. OMH did not provide the Justice Center with a written policy but stated that is their expectation that staff will provide coverage when another staff is out. OMH provided the Justice Center with documentary evidence that the first inmate-patient was seen in the appropriate timeframes. The second inmate-patient was not seen in accordance with CNYPC CBO Policy because of staffing shortage, therefore CNYPC CBO Policy #9.30 – Progress Notes and #2.4 – Canceled/Refused/Missed Callouts were reviewed with clinical staff.

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

A review of the clinical case records found that an inmate-patient was not seen by clinical staff in accordance with CNYPC CBO policy when they completed a SHU to SHU transfer. The Justice Center requested documentation that the inmate-patient was seen. OMH indicated that clinical staff had erroneously documented that the inmate-patient had transferred to a OMH Level 1 facility when they had actually transferred to a OMH Level 3 facility, therefore the inmate-patient was seen in the appropriate timeframe. To address the error, OMH retrained their staff in CNYPC CBO Policy 9.7 – Chronological Record.

The Justice Center determined that an inmate-patient's psychiatric call out was not rescheduled at the Southport CF in accordance with CNYPC CBO policies. To confirm that inmate-patients are monitored in the appropriate time frame and documentation complete, the Justice Center

recommended that OMH retrain all psychiatric mental health staff in CNYPC CBO Policy #2.4 - Canceled/Refused/Missed. OMH indicated that the CNYPC CBO Policy was reviewed with psychiatric staff; however, at the time, there was no psychiatrists on-site and all call outs were completed via Video-Teleconferencing.

Groveland CF

Visit Overview: Visit conducted on November 20, 2019; 19 cell-side interviews conducted with three private interviews accepted; five inmate-patients were referred to a mental health clinician; 13 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: 13 records were reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

Per documentation received, an inmate-patient was not seen in accordance to policy when a mental health referral was filed on his behalf. The Justice Center requested that OMH staff be retrained in CNYPC CBP Policy #1.3 – Mental Health Referrals and that the Unit Chief should complete quality assurance checks to ensure that inmate-patients are monitored in the appropriate timeframe. In addition to the training, documentation demonstrating that the inmate-patient was seen by psychiatric staff was requested. OMH acknowledged that the inmate-patient in question was rescheduled however, missed that appointment and an additional progress note was not written. Therefore, CNYPC CBO Policy #2.4 - Cancelled/Refused/Missed Callouts was reviewed with the treatment team instead.

Woodbourne CF

Visit Overview: Visit conducted on December 10, 2019; four cell-side interviews conducted with one private interview accepted; two inmate-patients were referred to a mental health clinician; two records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: Two records were reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

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

The Justice Center found that an inmate-patient was not seen in in the appropriate timeframe following a facility transfer to the Mid-State CF. As this had been cited as a concern in October 2019 at the Mid-State CF, the Justice Center did not request any additional training as OMH acknowledged at that time, that staff had been retrained in CBO CNYPC Policy #9.30 – Progress Notes and the Unit Chief would be reviewing the schedules of incoming drafts to ensure that they are scheduled to be seen according to policy.

Marcy CF

Visit Overview: Visit conducted on December 19, 2019; 27 cell-side interviews conducted with four private interviews accepted; four inmate-patients were referred to a mental health clinician; 16 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were no inmate-patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and no inmate-patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: The Justice Center determined that the facility was in compliance with the required timeframes in the SHU Exclusion Law.

QMHC Findings: 16 records were reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

Chronological Records were not completed in accordance with CNYPC CBO Policy #9.7 – Chronological Record. The Justice Center recommended that staff be retrained in CNYPC CBO Policy #9.7 and that the Unit Chief complete quality assurance checks to ensure accurate and updated information in the clinical case record. OMH indicated that the policy was reviewed with the pertinent staff.

The Justice Center found that an inmate-patient was not seen in in the appropriate timeframe following a facility transfer. As this had been cited as a concern in August 2018, the Justice Center acknowledged that staff had been retrained in CBO CNYPC Policy #9.30 – Progress Notes and CNYPC CBO Policy #2.4 - Cancelled/Refused/Missed Callouts. Furthermore, the Unit Chief would increase the amount of quality assurance checks to ensure that inmate-patients were seen in the appropriate time frame. The Justice Center recommended the OMH clinical director review the quality assurance checks completed, retrain OMH staff again in CBO CNYPC Policy #9.30 and continue completing quality assurance checks. OMH indicated in their response that they did retrain staff in CBO CNYPC policy #9.30 and that the Regional Forensic Program Administrator would be the more appropriate staff member to review the quality assurance checks. OMH also noted there have been improvements in this area and random spot checks would continue.

A clinical case record review found that there were inconsistencies in diagnosis for an inmate-patient. The Justice Center requested that the OMH clinical director complete a clinical review and forward any documentation pertaining to the inmate-patient's mental health current

diagnosis. In response, OMH shared the inmate-patient's most recent diagnostic changes and current mental health diagnosis which addressed the previously noted inconsistencies.

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Summary of Mental Health Service Review of Findings

The Justice Center completes a review of the quality of mental health care provided to all inmate-patients for the six months before the suicide occurred if they were on the mental health caseload at the time of their death. One mental health service review was completed during this quarter at the Elmira CF.

Background

In January of 2019, the inmate was a Mental Health Service Level (MHSL) 6 housed in general population. Following disciplinary sanctions, the inmate adjusted adequately to Long Term Keep Lock (LTKL) and denied any mental health symptoms. Following a referral from security staff, the inmate explained to the mental health staff member that he was seeing and hearing spirits telling the inmate he was going to die. The inmate denied any recent drug use and therefore was admitted to the Elmira Residential Crisis Treatment Program (RCTP) and placed on active screen status for further assessment. During his admission medication options were discussed with the inmate, however the inmate declined medication, denied suicidal ideation and was discharged back to the LTKL; the inmate's MHSL was updated to a 4 and he was diagnosed with an Adjustment Disorder with Anxiety.

Two days later, the inmate was admitted to the RCTP for psychiatric decompensation, psychiatric staff visited with the inmate-patient cell side and documented that he refused to meet in private but stated "I had a break down." They again declined any psychiatric medication and after a few additional days, the inmate-patient presented as "future oriented" and ready to go back to their regular cell, denying any thoughts of harming himself or others. Due to additional disciplinary sanctions the inmate-patient was transferred to the SHU and presented as calm, again denying as any mental health concerns or suicidal ideation. Two days later, the inmate-patient passed away due to hanging.

Justice Center Findings/Recommendations and OMH/DOCCS Response:

The Justice Center found that OMH failed to recognize the suicide risk factors and warning signs displayed by the inmate-patient. Additionally, his symptoms appeared to increase and there was minimal documentary evidence that additional support, programming or diverse psychotherapeutic approaches were offered. The Justice Center requested that the OMH Clinical Director review the inmate-patient's clinical case record for clinical content and appropriate assessment of his documented symptomology leading up to his suicide.

It was also determined that the inmate-patient was discharged from the Residential Crisis Treatment Program (RCTP) Observation Cell directly to the Long Term Keep Lock (LTKL) and Special Housing Unit (SHU) on two separate occasions. It did not appear that there were any step-down services to support the inmate-patient even though his mental health symptoms increased after re-admission to the LTKL. The Justice Center acknowledged that although OMH followed CNYPC's policies and procedures in discharging the inmate-patient from the RCTP, best practice would have been to implement a step-down process prior to discharge from RCTP status. Given the findings, the Justice Center recommended that OMH assess how best to

ensure OMH staff understand and follow through on best practices for a step-down process for discharge from RCTP.

OMH indicated in their response to both findings that the inmate-patient's death was reviewed by their Incident Review Committee and Mortality Review Committee, which included the CBO Clinical Director and members of the CNYPC Administration. The CBO Clinical Director found that OMH appropriately referred the inmate-patient to medical to rule out medical issues or substance abuse and attempted to prescribe medications to address mood instability and mental health concerns, but the inmate-patient continuously refused and stated he did not need them. It was also noted that best practice for one patient may not apply to another and step-down services upon discharge from the RCTP is a matter of clinical determination on a case by case basis. The inmate-patient was viewed as having a positive therapeutic rapport and was amendable to receiving help and treatment, but made OMH staff aware on several occasions that he was concerned about the stigma of being on the mental health caseload and therefore showed minimal compliance with same.