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Residential Crisis Treatment Program(s) Follow-up Review

INTRODUCTION

Incarcerated individuals in need of an immediate mental health evaluation, and/or observation and treatment, are required to be transferred to a Residential Crisis Treatment Program (RCTP) which operates within sixteen correctional facilities. According to the Central New York Psychiatric Center's (CNYPC) policy #4.0, RCTP Observation Cells, "A cell located in an RCTP is designed to enhance inmate-patient safety and facilitate observation and assessment during a crisis."

In 2010, the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) completed a review of the RCTPs and found that while RCTPs were beneficial for many inmates, more should be done to maximize the therapeutic nature of the programs. Based on that review, CQC received a number of complaints from inmates and advocacy groups regarding issues within the RCTPs related to the length of stay of patients, the temperature in the units, inadequate amenities, staff training and dorm utilization¹. While these issues were originally addressed in CQC's 2010 report², given the number of complaints received, CQC decided to conduct follow-up visits to the RCTPs to determine whether its recommendations and corrective actions were implemented.

The follow-up review established that complaints regarding RCTP temperatures, staff training and dorm utilization were unfounded; however, CQC found that the Office of Mental Health (OMH) documentation does not accurately or fully describe a patient's current mental health status, mental health history, risk factors and suicide attempts which continue to be an issue. In addition, we had several concerns about the clinical care and assessments received by patients during their stay in the RCTP, such as:

¹ Central New York Psychiatric Center (CNYPC) Corrections Based Outpatient (CBO) Policy #4.1 RCTP Dorm – staff will utilize RCTP dorm beds to safely house inmate-patients for the purpose of observing behavior, monitoring treatment efforts and/or providing respite care.

² See Appendix 1 for all of the recommendations from this review.

- Underlying issues are not thoroughly explored causing extended stays in the RCTP.
- There is no continuity of care between the inmate/patient's housing unit clinical treatment team and the RCTP clinical treatment team.
- There is no OMH policy related to the process of calculating patient lengths of stay in the RCTP which could potentially alter the continuity of care and data trending.³
- The RCTP Observation Referral to the Clinical Director/Designee form, lacked detailed information for clinical opinions and/or recommendations for further treatment.
- Two patients warranted further psychiatric review of their past and present course of treatment.
- Amenities were restricted without justification at two facilities.

On February 7, 2013, CQC sent a draft of its findings and recommendations to the Department of Corrections and Community Supervision (DOCCS) and the Office of Mental Health (OMH) who responded on February 26, 2013 and March 26, 2013, respectively. DOCCS and OMH agreed with CQC's findings and recommendations. CQC has summarized the responses within the recommendations section and have included the entire responses as an attachment.

METHODOLOGY

To conduct the review, CQC staff visited five correctional facilities which included Clinton, Elmira, Five Points, Great Meadow, and Sullivan. Staff toured the RCTP and reviewed the OMH clinical case records as well as the DOCCS' guidance records of 30 patients for the time period June 2011 to November 2011. While on site, CQC reviewed the DOCCS RCTP logs, which documented the temperature of the unit, rounds conducted by mental health staff, suicide watches, and unit activity. CQC staff also interviewed 26 inmate/patients, 15 OMH clinical staff members, and 18 DOCCS staff members.

CQC FINDINGS

Findings related to Documentation:

1. OMH failed to act on risk factors and did not properly document suicide attempts.

According to CNYPC's Comprehensive Suicide Risk Assessment (CSRA) Process Policy #1.0, "the CSRA process begins at the time an OMH clinician screens an inmate or admits the patient to services. This assessment is an ongoing process from admission to discharge to ensure patient safety and timely interventions and to maximize positive

³OMH tracks data related to an inmate/patient's length of stay longer than seven days, as well as inmate/patients who were transferred into RCTP three or more times in six months.

patient outcomes. If an inmate is admitted to services, the clinician assesses and documents the acute and chronic risk factors, protective factors, notes the presence or absence of warning signs of imminent suicide risk, and documents a plan of action to address any suicide risk identified.” The following are examples of two patients CSRAs which were found to be inadequate:

- (a) Patient #1⁴ had several inpatient hospitalizations prior to her current DOCCS incarceration due to suicidal ideation and attempts. The patient presented in the RCTP on June 9, 2011, with acute signs for suicide and a possible psychosis. The patient was discharged back to the Therapeutic Behavioral Unit⁵ (TBU) the same day and reminded how to access mental health services. The CSRA for the patient was completed on June 17, 2011, indicating the patient was experiencing current suicidal ideation/intent. The following recommendations⁶ were made on the patient’s CSRA: increase the frequency of therapy sessions, consult with the Treatment Team/Unit Chief, consult with the Psychiatrist/Nurse Practitioner and discuss with DOCCS. There were no progress notes in the patient’s clinical record to support that either consults with the clinical treatment team members, or a discussion with DOCCS took place, in reference to this patient. Two days later, on June 19, 2011, the patient made a serious suicide attempt, when she was found cyanotic and had to be cut down in her cell after an attempted hanging. The patient’s CSRA was updated⁷ on June 21, 2011, which included the suicide attempt and the need to be presented for admission to CNYPC, to which the patient was accepted. A new CSRA was completed upon the patient’s admission to CNYPC on June 24, 2011, and many of the risk and protective factors⁸ identified three days earlier were not documented on this new CSRA.
- (b) Patient #2 was admitted to the Sullivan RCTP on August 12, 2011, due to threats of self-harm. A CSRA was completed on that date identifying eleven risk factors, including prior mental health history, psychiatric hospitalizations, and prior suicidal ideation/threats/gestures. According to progress notes, the patient continued to exhibit significant risk factors, but the updated⁹ CSRAs, dated August 30 and September 15, 2011¹⁰, indicated there were no risk factors.

⁴ See Appendix Key.

⁵ The Therapeutic Behavioral Unit (TBU) is a program for female inmates serving Special Housing Unit (SHU) time who have a history of mental illness and/or poor custodial adjustment. This program is located at the Bedford Hills Correctional Facility.

⁶ CNYPC CBO Policy #1.0, Comprehensive Suicide Risk Assessment (CSRA) Process, “Results and recommendations from the suicide risk assessment are taken into consideration when developing and updating the treatment plan and in making the decision regarding whether to admit to a higher level of care.”

⁷ CNYPC CBO Policy #1.0, Comprehensive Suicide Risk Assessment (CSRA) Process, “The CSRA form should be updated as clinically indicated, that is, when significant changes occur relevant to risk factors, protective factors or to a patient’s treatment plan goal related to suicide.”

⁸ See Attachment #1.

⁹ CNYPC CBO Policy #1.0 Comprehensive Suicide Risk Assessment, Each time a primary therapist or psychiatrist/nurse practitioner has a clinical contact with a patient, the presence of warning signs and/or changes in the risk and protective factors is assessed and documented in a progress note. The CSRA form is updated with any new information or changes in any information previously documented on the form. Suicide risk will be addressed on each formatted primary therapist progress note and RCTP Daily Progress Notes. Changes in risk or protective factors, discussion of warning signs, assessment of patient’s current functioning, and description of suicide risk-

2. Mental Health daily progress notes did not always reflect a patient's current mental health status.

CQC found that clinical progress notes did not always provide an accurate representation of a patient's current mental status. For example:

- (a) On five different occasions between September 2 and 9, 2011, Patient #2 refused to respond to a clinician or accept a confidential interview while in the Sullivan RCTP. The RCTP Observation Daily Progress Note indicated there were no changes in chronic or protective risk factors on the CSRA, which would be difficult to assess based on the patient's presentation.
- (b) Psychiatric progress notes dated August 22 and 23, 2011, for Patient #3 at the Sullivan RCTP stated, "refused to come out today." However, CQC could not find any documentary¹¹ evidence in the patient's clinical record that a cell-side interview was conducted, or that the patient was encouraged by mental health staff to be evaluated.

3. RCTP monitoring charts were incomplete.

Consistent with CQC's 2010 review, we found instances where RCTP monitoring charts¹² were incomplete. For example:

- (a) Patient #2's monitoring chart for August 30, 2011, September 9, 2011¹³, was either not completed for the date/time ended section and the date/time transferred out of RCTP section or was not signed by a clinical staff. The patient's September 19, 2011, psychiatric progress note was incomplete and only stated, "Pt. seen in the interview is mute, uncooperative and refuses to talk," all other areas on the form were left blank. The patient's September 30, 2011, and October 7, 2011, psychiatric progress notes were also incomplete.
- (b) Patient #4 has an extensive documented history of swallowing objects when stressed, and has claimed these actions are not done in an attempt to commit suicide, but rather to achieve a trip to a hospital to "escape from his mind." The patient was admitted to

related treatment plan will be documented on the primary therapist progress notes and RCTP Daily Progress Notes. Suicide risk, any changes to the risk factors, protective factors and warning signs, and review of the CSRA form will be documented in the structured psychiatric progress note.

¹⁰ See Attachment #2.

¹¹ RCTP Observation Daily Progress Note and RCTP Nursing Progress Note.

¹² CNYPC CBO Policy #9.24 RCTP Monitoring Chart must be started when an inmate-patient physically arrives in an RCTP observation cell, and updated with any changes as they occur by the RCTP Coordinator, Primary Therapist or Nursing staff. Individualized clinical reasons for non-approval or removal of any of the minimum cell items must be documented in the designated column of the table labeled "Minimum Observation Cell Items." Additional items provided are documented in the table labeled, "Additional items." In the event of the transfer of an inmate-patient to a cell when no OMH staff are on duty, the Department of Corrections staff will make a determination regarding watch status and cell items to be given, however, OMH staff will review at the earliest possible opportunity (at the beginning of the next mental health shift) and make any necessary adjustments based upon the clinical assessment.

¹³ See Attachment #3.

the Five Points RCTP from the Marcy Residential Mental Health Unit (RMHU) on August 23, 2011, after swallowing unidentified objects. The RCTP Nursing Assessment indicated that the patient was experiencing suicidal ideation and had an active suicide plan. The psychiatric and clinical progress notes, dated August 24, 2011, indicated that an out-of-cell interview was conducted with the patient, and the interview focused on the patient's anger regarding being placed on a contraband watch by DOCCS staff. The patient denied suicidal ideation and was prepared for discharge. However, there were no clinical progress notes to support that a discussion took place with the patient regarding what led to the RCTP admission or what strategies the patient could use to prevent further admissions. Subsequently, the patient was released from the RCTP on August 24, 2011, at 12:00 p.m. but then readmitted at 3:00 p.m. due to "threats of self-harm." Furthermore, the patient was discharged and readmitted into the RCTP two additional times between August 28, 2011, and September 13, 2011. The patient's Five Points RCTP monitoring chart, dated August 24 and 25, 2011, was not signed by a mental health staff. The patient's September 12 and 13, 2011, monitoring chart also documented that soap, toothbrush, and eating utensils were not given, but the date of removal and by whom was left blank. A rationale was documented in the "Reason for Removal" section as "Hx eating small items." However, the patient was provided all additional items, including a bendable pen, on September 13, 2011, but still was not documented as having received personal care items, such as soap, toothbrush and eating utensils.

Clinical Care and Assessments:

1. Underlying issues are not thoroughly explored causing extended stays in RCTP.

CQC found instances in which some patients, while in the RCTP, exhibited feigning and malingering behaviors in an effort to address security issues¹⁴. While mental health staff did not always fully explore these behaviors, the behaviors did affect engaging in treatment. This resulted in patients, at times, spending months in RCTP when their primary focus was for "secondary gain." Some inmate/patients interviewed by CQC staff reported utilizing the RCTP so that they could be moved to a different facility or removed from a specific housing unit. As one inmate/patient stated, "desperate times call for desperate measures." The inmate/patient also reported that he had to follow through with a suicide attempt once admitted to the RCTP to show the seriousness of his mission, even though he understood that it could end in an accidental death. Other examples noted by CQC included:

- (a) Patient #5 was involved in a fight with his bunkmate on July 18, 2011, at the Five Points Correctional Facility. The DOCCS Fight Investigation Report documented the patient "does not want a bunkmate.....is aggravating cell mates thinking the Administration will make him a single cell." The patient was admitted to the RCTP on July 29, 2011, due to not eating and feeling depressed. The patient stayed in the RCTP for two months and did not show any signs of improvement. Progress notes

¹⁴ Pending tickets.

during this admission indicated the patient did not want to be double-bunked, and was “not eating” to make a point. The RCTP Observation Referral to the Clinical Director/Designee form, dated August 16, 2011, stated that the patient’s “issues appear to be based on secondary gain, and not related to the depressive and anxious symptoms.” The patient had also reported to CQC that he had no complaints about the treatment from either OMH or DOCCS staff during the RCTP stay, and only expressed appreciation for not having to be double-bunked in SHU due to the RCTP admission. It appears that the patient may have been utilizing the RCTP to avoid double-bunking. Based on documentation reviewed by CQC, this admission appeared to be the first contact the patient had with correctional mental health, other than when the SHU assessments were completed. The patient was ultimately placed into a single cell, but there is no documentation that mental health staff attempted to explore the underlying cause why the patient did not want to be in a double-bunk cell, even though upon admission a progress note indicated the patient reported assaults by bunkmates.

- (b) On July 30, 2011, Patient #6 received a Tier 3¹⁵ ticket for a weapon while in the Elmira Correctional Facility. Two days later, the patient was admitted to the RCTP for suicidal ideation and his stay lasted 96 days. The clinician noted that this was the patient’s first mental health contact ever. Throughout his stay, progress notes indicated that he was expressing thoughts of killing himself, and at times, acted upon them by swallowing objects or cutting himself. These acts resulted in four separate admissions to the infirmary. Throughout the patient’s stay in the RCTP, mental health staff continued to attempt to explore the patient’s reasons for his suicidal ideations, but the patient would either not answer questions, or would talk about “voices” telling him what to do. Clinical progress notes also indicated that the patient did not present as depressed or that he was responding to internal stimuli. The patient would at times make comments that he could not be held there due to harming himself and progress notes indicated his goal was to go to CNYPC as he was having difficulty accepting his weapon charge. From documentation reviewed, it appears that DOCCS staff attempted to speak with the patient and encourage him to accept his ticket and complete the hearing process.¹⁶ There were several consultations documented with clinical directors, but most gave direction to continue monitoring the patient in the RCTP. On November 4, 2011, the consultation note directed, “look for 4301¹⁷ @ Wende CF.” A progress note on November 7, 2011, stated, “patient has been in observation cell for three months and has resisted attempts to move him out. Plan is to send him to a different RCTP.” The psychiatric progress note on November 9, 2011, indicated the “patient reported doing a little better, and had started medications and felt they are going to help, though he is still depressed but there is no suicidal thoughts, plan or intent at this time.” An RCTP observation daily progress

¹⁵ Inmates receive Tier 3 tickets for the most serious offenses. Penalties can include SHU, restricted diet and recommended loss of good time. The facility superintendent reviews all Tier 3 reports and sentences may be appealed to the Commissioner of DOCCS within 30 days.

¹⁶When an inmate receives a Tier 3 ticket, a disciplinary hearing takes place at which time the inmate can attend, but may also refuse to attend. The inmate does not receive their penalty until a hearing takes place.

¹⁷ 4301 is the DOCCS Directive which refers to transferring an inmate-patient between OMH satellite units.

note for the same date stated that the patient would be released to SHU that afternoon. “His change of heart appears to be attributed to a couple hypotheses... he may have just gotten tired of being in the RCTP or the anti-depressants are actually helping his mood and outlook on life.”

2. There is no continuity of care between the inmate/patients’ housing unit clinical team and the RCTP clinical team.

The purpose of the RCTP is to provide a therapeutic environment in which an individual can be observed, monitored and stabilized for symptomatic reasons, stress, or psychiatric decompensation. However, CQC found during the course of our review of clinical case records and interviews with patients and staff that many patients were having difficulty engaging in treatment during their placement in the RCTP. Communication among patients, clinical staff and others is the key in therapeutic relationships, especially when clinical staff offers effective listening skills, allowing patients to express their concerns, stressors, and psychiatric challenges and build trust. Within the current structure of the RCTP, there appears to be a lack of continuity of care for patients. Most patients are admitted into the RCTP at the highest level of clinical need and are expected to engage immediately with new clinical staff, many of whom they have never met before. Seriously mentally ill inmate/patients may find frequent changes in clinical providers frustrating which may lead to a lack of trust and added stress. Additionally, CQC found no documentation that the housing unit clinical team provides any input to the treatment team meetings while an inmate/patient is in RCTP, or that the housing unit clinical team is involved in the inmate/patient’s discharge planning from the RCTP.

3. Mandatory clinical director consultations¹⁸ lack detailed information to provide clinical opinion and/or suggestions for further treatment.

(a) Patient #2 was admitted to the Sullivan RCTP on August 30, 2011, and remained there until September 9, 2011, at which time the patient was transferred to the Great Meadow RCTP and remained there until September 13, 2011, for a total of 14 days in an RCTP. There was no RCTP Observation Referral to the Clinical Director/Designee form completed for that RCTP length of stay. The patient was later readmitted back to the Sullivan RCTP on September 15, 2011, for 32 days, at which time only one RCTP Observation Referral to the Clinical Director/Designee form was found in the record. The RCTP Observation Referral was submitted on October 7, 2011, and indicated that the patient was transferred to the Sullivan RCTP on October 5, 2011, which is incorrect; the patient was admitted on September 15, 2011. On the RCTP Observation Referral to the Clinical Director/Designee form a recommendation was made for the patient to remain in the RCTP for further observation and treatment/stabilization. The consultation did not provide any insight into the patient’s mental health and/or treatment regimen.

¹⁸ CNYPC CBO policy #4.0, RCTP Observation Cells, B. 6. Length of Stay Greater Than Seven Calendar Days, A. states, “A consultation with the Regional Psychiatrist, Clinical Director or Designee must occur if an inmate-patient remains in an RCTP observation cell in excess of seven calendar days.”

(b) Patient #7 was admitted to the Bedford Hills RCTP following a suicide attempt on September 1, 2011. Clinical progress notes, dated September 6, 7, and 8, 2011, documented that the patient would be presented to CNYPC for admission the following week. The patient's case was presented on September 9, 2011, to Dr. Kaplan (Outpatient Clinical Director) and Dr. Inaganti (Regional Medical Director), and the only documentation found regarding the consultation stated, "patient was approved for continued OBS (observation) admission." The documentation did not have a rationale as to why the patient would not be admitted to CNYPC, or give any recommendations regarding a plan for further treatment and/or stabilization within the RCTP.

4. Clinical decisions regarding the appropriate level of care for inmate/patients in the RCTP are not based on an inmate/patient's total length of stay, leading to deficient continuity of care and multiple admissions to the RCTP.

During an RCTP admission, inmates/patients may require services such as the infirmary or an outside hospital's medical services which are not offered by the RCTP. If an overnight stay is required to provide these services, the inmate/patient is discharged from the RCTP and then readmitted the next day upon return to the RCTP, leading to multiple discharges/admissions to and from the RCTP within a short period of time. The clinical director determines the appropriateness of continued monitoring in the RCTP based on the number of days the inmate/patient has been admitted to the RCTP for the current stay, rather than on the total number of days the inmate/patient has been there within a certain timeframe. Therefore, patients who may be in need of a higher level of care are instead deemed appropriate for continued monitoring in the RCTP, rather than being adequately evaluated for more suitable services, thus leading to a disruption in continuity of care and multiple RCTP admissions. For example:

Over a 123-day period in the RCTP, Patient #6 was discharged and admitted back to the RCTP from the infirmary on three different occasions for acts of self-harm. Each time the patient was readmitted to the RCTP, clinical progress notes did not reflect the prior admission(s) regarding assessments and progression of treatment.

5. Two patients warranted further psychiatric review of their past and present course of treatment.

While reviewing Patient #8's records, CQC had concerns with the multiple admissions to RCTP. Patient #8 has been incarcerated since May 2009 and resided in the TBU from January 2010 to January 2011 at which time she received additional tickets and had 43 RCTP admissions. Between May 2011 and November 2011, the patient was admitted to the RCTP on at least 14 occasions.

Additionally, CQC was asked to review Patient #9's care even though the patient was not part of the overall RCTP review.

CQC contacted Stuart Grassian, M.D.,¹⁹ a member of CQC's Psychiatric Correctional Advisory Committee, and requested assistance in reviewing the documentation obtained during CQC site visits for the two patients. CQC also made OMH aware of these two patients and Dr. Grassian's review of their records.

Dr. Grassian assisted CQC in reviewing the documentation²⁰ obtained during our site visit for Patient #8. Dr. Grassian opined that patient #8's diagnoses included Bipolar Disorder NOS, Borderline Personality Disorder and Antisocial Personality Disorder. Dr. Grassian opined that the patient had some form of Bipolar Mood Disorder, likely one with mixed features (manifesting both manic and depressive emotions and behavior virtually simultaneously). While the patient was being treated with mood stabilizing medication (Lamictal), it clearly was not sufficient to contain the patient's symptoms. The medication management should have more aggressively addressed the patient's mood instability, and a hospital environment would have been more likely to improve her condition. The patient's statement that she was suicidal or homicidal was treated as simply "manipulative" to get transferred to CNYPC, but this ignored the fact that the patient was symptomatic with bipolar mood disorder.

OMH responded²¹ that Patient #8 carried a diagnosis of Bipolar Disorder while receiving treatment at Bedford Hills during her current period of incarceration but the basis for that diagnosis has been questioned in light of her remarkably different presentation when receiving inpatient treatment at CNYPC during August and September 2012. It appears possible that the patient's disturbances of mood and behavior are the result of co-morbid Axis II diagnoses and for that reason her treatment for mood instability has been conservative compared to the more aggressive treatment recommended by Dr. Grassian. Patient #8 has been considered for re-hospitalization as her December 6, 2012, Maximum Expiration date of sentence approaches, but at this time, her presentation has not met the criteria for emergency commitment. CNYPC Pre-Release Coordination staff is well aware of patient #8's upcoming release date and are developing a discharge plan that will take into consideration the patient's psychiatric condition and community placement options. She will be continued to be assessed closely until her release.

Patient #9, is a 33-year-old who has an extensive history of inpatient hospitalizations dating back to age 15, as well as a criminal history beginning at age ten with incarceration at age 16. Due to the patient's problematic behavior while incarcerated, the patient has essentially resided in the Special Housing Unit (SHU) and has lost any "good time"²². The patient has been designated a mental health level 1S

¹⁹Stuart Grassian, M.D., is a psychiatrist who has testified as an expert in a large number of individual and class-action lawsuits challenging the toxic psychiatric effects of stringent conditions of incarceration and the inadequacy of mental health services provided inmates.

²⁰ Dr. Grassian reviewed patient #8's OMH clinical records and DOCCS guidance records for the timeframe of 6/1/11-11/30/11.

²¹ CQC forwarded Dr. Grassian's review and suggestions to OMH for response.

²² An inmate may earn time allowances (good time) off his or her maximum term of imprisonment for good institutional behavior.

(seriously mentally ill), and as a result of ongoing behaviors and his serious mental illness, has remained in segregated confinement as an “exceptional circumstance”²³.”

After a review of clinical and DOCCS guidance records²⁴, Dr. Grassian opined that patient #9 was very impulsive, irritable and his actions chaotic and violent, not planned, not the product of any rational calculus of risk and benefit, of means and ends. The patient’s behaviors included, but were not limited to, making threats, displaying aggression and throwing food and feces, etc. In response to these behaviors, which were exhibited on a continuous basis, the patient received a confinement sanction. Dr. Grassian opined that the patient clearly had some form of Bipolar Mood Disorder and it is typical that the patient has both Attention Deficit Hyperactivity Disorder (ADHD) and polysubstance abuse. While the patient’s diagnosis changed over time, his behaviors did not. The patient’s mood had been dysregulated during much, or most of his incarceration, and his behavior during these periods of dysregulations should not be used as evidence of personality disorder. Dr. Grassian also noted that some of the diagnoses in the patient’s record (i.e., Intermittent Explosive Disorder and Cyclothymic Disorder) are just variants of Bipolar Mood Disorder.

The collateral information which was provided in the record did not offer enough information to understand the dysfunctional history and what treatment worked in the past with the patient. Although the record alluded to a number of psychiatric hospitalizations in a number of different psychiatric venues,²⁵ the record did not provide detailed information about what led to the hospitalizations and whether and in what way his condition improved during those hospitalizations. This information is critical to understanding the nature of his dysfunction. The record also alluded that as a child, Ritalin had an important effect, making the patient quiet and calm. This is a very substantial positive response to the drug. While the Commission and Dr. Grassian understand that Ritalin and other stimulants are generally not prescribed in correctional facilities due to the danger of abuse, there are other non-stimulant ADHD drugs available that are not potentially drugs of abuse. The record also indicated the patient’s mother had a history of major mental illness, resulting in hospitalization, and the patient was raised by a relative who is listed as the collateral contact, but there is no indication in the record that anyone attempted to contact this relative to get a more complete past history and family history.

²³ N.Y. Cor. Law §137: NY Code – Section 137: Program of treatment, control, discipline at correctional facilities. “A recommendation or determination shall direct the inmate’s removal from segregated confinement except in the following exceptional circumstances: (1) when the reviewer finds that removal would pose a substantial risk to the safety of the inmate or other persons, or a substantial threat to the security of the facility, even if additional restrictions were placed on the inmate’s access to treatment, property, services or privileges in a residential mental health treatment unit.”

²⁴Dr. Grassian reviewed patient #9’s OMH clinical record from 6/1/11 to 11/30/11 as well as clinical records from two CNYPC admissions, 1/18/01 – 1/31/01 and 12/23/09 – 1/7/10 and patient #9’s DOCCS guidance record from 6/1/11-11/30/11.

²⁵ Harlem, Kirby, Bronx, Mid-Hudson and Central New York Psychiatric Centers.

OMH Responded²⁶ that psychiatric staff at Wende and Elmira Mental Health Satellite Units (MHSUs) have repeatedly attempted to start patient #9 on various medications felt to be appropriate for his presentation. In each instance, the patient has refused to consider taking the medication or refused the medication following a brief period of medication compliance. Psychiatric staff have thoroughly been involved in the assessment of the patient on a variety of diagnoses which have included Dr. Grassian's recommendations for ADHD as well as his definitive diagnosis of Bipolar Disorder. While not dismissive of Dr. Grassian's expertise nor his input regarding these difficult cases, CNYPC psychiatric staff have based their diagnostic impression of the patient on years of actual clinical contacts and evaluations in addition to the review of the inmate-patient's psychiatric history and remain confident that the patient's presentation is consistent with his current diagnosis of Antisocial Personality Disorder.

In response to the collateral information, patient #9's OMH staff have reviewed his record to determine if there is the need to obtain further information regarding the patient's psychiatric history. The discharge summaries from psychiatric hospitalization dating from 1994 through 2007 are included in the patient's OMH record and provide information regarding the presenting problem upon admission as well as response to the various treatment paths taken during those admissions. CNYPC staff agrees with Dr. Grassian's recommendation that a collateral contact listed in the patient's OMH record be contacted to obtain information regarding his family psychiatric history. However, attempts to make contact with anyone connected to the patient in the community have been hampered by his refusal to sign Release of Information forms.

The Wende MHSU treatment team has been apprised of Dr. Grassian's input and is considering his treatment recommendations especially in regard to mood stabilization as they continue to attempt to engage patient #9 in any form of psychiatric treatment. As with all inmate-patient's information, the patient's past treatment episodes is being continually evaluated and considered during the course of the treatment team's efforts to provide effective treatment to the inmate-patient. Efforts to continue toward convincing patient #9 to cooperate with staff efforts toward obtaining more complete background information from family members or other sources.

Environmental Concerns

1. Amenities were restricted without justification.

CQC had received complaints that mattresses at the Elmira RCTP were removed during the summer months of 2011, and that patients were not given eating utensils.

During our site visit to Elmira in December 2011, CQC learned that patients were picking at the stitching of the mattresses and using them to harm themselves, as well as using

²⁶ CQC forwarded Dr. Grassian's review and suggestions to OMH for response.

them as sleeping bags. CQC was also informed that DOCCS Central Office gave a directive to remove the mattresses to ensure the safety of the patients in the RCTP, and to provide time for new mattresses to be created. Upon removal of the mattresses, two additional mats were given to the patients until the new mattresses arrived. While touring the RCTP, CQC found all cells had the new mattresses. During CQC's review of documentation, however, we found that Elmira never provided the patients with any explanation for their actions, which probably caused the number of complaints.

While complaints of the mattress issue appeared to be specific to the Elmira RCTP, CQC did find during record reviews another instance of a mattress issue at the Bedford Hills RCTP.

Patient #10 was admitted to the Bedford Hills RCTP on November 22, 2011, following threats of self-harm. The monitoring sheet for the patient indicated that all amenities were provided, minus a toothbrush and eating utensils, due to the patient's current presentation. The monitoring sheet also documented "no mattresses available" and a fourth mat was provided. There was no justification documented as to why there were no available mattresses, or that the patient was told why a mattress was not provided.

During our site visit to Elmira, patients told CQC that they were not allowed eating utensils, even though their individual RCTP admissions were not precipitated by acts of self-harm. Record reviews of these individuals confirmed on their monitoring sheets that they were in fact not given eating utensils. CQC was informed by the Deputy Superintendent of Security at Elmira that there was a period of time, prior to our site visit, that patients were not receiving eating utensils, regardless of the reason for admission to the RCTP. The state-issued utensils were found to be breakable, and due to self-harm concerns, the utensils were removed. CQC learned that Elmira RCTP is now using utensils that are bendable, but not breakable. While we understand that measures need to be taken to ensure patient safety, especially for those who make threats of self-harm, the other patients who are admitted to the RCTP for reasons other than self-harm should have been given utensils. There was no alternative offered to the patients, leading them to eat with their hands, or tear off a piece of the cardboard tray to use as a scoop. There was also no justification, clinical or otherwise, documented on their monitoring sheets to reference the reason for the removal of their utensils.

RECOMMENDATIONS

1. OMH should closely monitor clinical documentation to ensure that appropriate information and mental health history is documented.
 - a. Clinical staff should document all efforts to engage an inmate/patient in treatment; this includes progress notes related to treatment goals and objectives.

OMH Response

OMH understands the importance of thorough documentation which continues to be a focus of CNYPC training efforts and staff competency reviews. During the fall of 2012, all Mental Health Satellite Unit Chiefs and Mental Health Unit Coordinators attended a presentation on the art of documentation. CNYPC was granted permission for staff to develop a training program based on the presentation and this program will become one of CNYPC's primary training objectives during 2013. The CNYPC Corrections-Based Operations (CBO) Chief Psychologist and Director of Social Work have focused on improving documentation as a major component of their work responsibilities. In recognition of the CQC recommendation, CBO Health Information Management (HIM) staff will include audits of RCTP documentation in order to monitor the results of the training efforts described above.

CQC Reply

CQC acknowledges the efforts made by OMH to ensure that documentation efforts are thorough and are in agreement with the new training initiative to be implemented in 2013.

- b. Review the accountability of the CSRA and provide additional training on recognizing and appropriately documenting risk factors.

OMH Response

The training of staff related to the Comprehensive Suicide Risk Assessment (CSRA) process and the review of staff competencies in the administration and documentation requirements of the CSRA have been and will continue to be a focus of CNYPC training and clinical supervision. The CNYPC Chief Psychologist has conducted a quality assurance and improvement project since 2011, routinely reviewing CSRA's completed by CBO clinicians and provides direct feedback and CSRA specific supervision to those clinicians where quality improvement is necessary. The CNYPC Education and Training Department has provided extensive training on the use of the CSRA as well. This emphasis on CSRA training demonstrates the CNYPC commitment to continuous review of CSRA competency including reliable recognition and documentation of suicide risk factors.

CQC Reply

CQC is pleased that the CSRA continues to be the focus of CNYPC training and clinical supervision, however, in addition to training and supervision, the CSRA, should continue to be adequately reviewed for its purpose and accountability.

- c. Ensure that all clinical documentation is completed according to policy and protocol.

OMH Response

As described in the OMH response to recommendation 1a above, CNYPC shares the CQC recognition of the importance of accurate and thorough clinical documentation which will be the subject of a state-wide training initiative during 2013.

CQC Reply

CQC is in agreement.

2. OMH should evaluate the treatment model of the RCTP to ensure that patients are receiving adequate mental health care in reference to their current mental health needs.
 - a. OMH should request a Joint Case Management Committee (JCMC²⁷) review for those patients believed to be malingering and feigning in RCTP.

OMH Response

Discussions related to inmate/patients believed to be malingering and feigning in the RCTP are held at correctional facility Executive Team meetings with DOCCS staff and these meetings are viewed as the equivalent of a Joint Case Management Committee (JCMC) meeting. At these meetings, inmate/patients in RCTP who present as expressing feigned psychiatric symptoms solely for secondary gain are discussed in an effort to fully explore the mental health and security aspects on the inmate/patient's situation in an effort to successfully resolve difficult cases.

CQC Reply

CQC acknowledges that both DOCCS and OMH work together to resolve difficult cases; however, if the intention of the meeting is to explore the mental health and security aspects in order to successfully resolve the difficult cases, these meetings should be documented and noted in the inmate/patient's clinical case record in order to assist in the continuity of care.

²⁷ DOCCS Directive #4933A – Joint Case Management Committees, the purpose of which is to review, monitor and coordinate the behavior and treatment plan for those inmates: (1) Assigned to SHU in a correctional facility designated as OMH level 1 or level 2 who are on the OMH mental health caseload; (2) Designated as Seriously Mentally Ill (SMI) by OMH who are housed in a separate keeplock unit as the result of a keeplock or SHU confinement sanction of more than 60 days; and (3) Assigned to SHU based upon a recent request to the JCMC from OMH or department staff.

- b. OMH should ensure that the patient's current clinical team communicates with the patient's general population/individual programs.

OMH Response

Based on the description of the methodology utilized to accomplish the CQC RCTP Follow-up Review, it appears that CQC staff did not observe RCTP Treatment Team meetings during the course of the review. Such meetings are held daily, Monday through Friday, at all RCTPs to discuss the status and treatment planning for all inmate/patients housed in RCTP. Chairing the RCTP Treatment Team Meetings are the satellite unit's Clinical Director and Unit Chief. Other participants in the meetings are the RCTP Clinical Coordinator and all staff that are involved in the inmate/patient's mental health treatment when they are not housed in RCTP. OMH is confident that the existing RCTP treatment model and treatment team meeting structure promotes daily communication between the various staff involved in an inmate/patient's treatment and allows for effective continuity of care when inmate/patients are admitted to RCTP, throughout their stay in RCTP and when they are discharged from RCTP back to their general population or special program housing location.

CQC Reply

CQC did not attend a RCTP Treatment Team meeting during our review, but we acknowledge that all clinical personnel take part in treatment team meetings, whether or not assigned to the RCTP. However, when inmate/patients are required to become acclimated to a new clinician during times of crisis, such as during an RCTP admission, this could exacerbate their anxiety and individual stress levels; inmate/patients are then required to revert back to their original clinician upon release. With the current treatment process of the RCTP, CQC continues to be concerned with the continuity of care during an RCTP admission.

- c. OMH should re-evaluate the way that the RCTP calculates a patient's "length of stay" and create a policy/protocol to provide clear directives of the RCTP process so that length of stays are consistent among RCTPs and clinical consultation occurs on a timely basis for people with long length of stays or repeat transfers into RCTP.

OMH Response

CNYPC has developed a program in its data management system, CNet, which calculates length of stay and provides e-mail notification of the need for RCTP staff to submit for clinical consultation. Re-evaluation of that CNet program has led to a planned modification which will insure that length of stay calculations are not affected by an inmate/patient's movement out of the RCTP for infirmary stays, hospital stays or other situations that interrupt a continuous RCTP treatment episode. The clinical consultation process will continue to be available to and utilized by

RCTP treatment teams per request for difficult cases independent of a length of stay calculation.

CQC Reply

CQC is pleased that a modification in CNet will assist in appropriate data collection for length of stay in the RCTP, and that clinical oversight will be enhanced with the CNet modification.

- d. OMH should evaluate the RCTP Observation Referral to the Clinical Director/Designee Form and provide directives for its usage to include better treatment oversight and treatment modality objectives.

OMH Response

In an effort to improve the quality of the RCTP consultation process, the RCTP Observation Referral to the Clinical Director/Designee Form has been standardized to ensure consistency across units and that appropriate information is clearly conveyed to the Clinical Director/Designees. CNYPC staff will continue to evaluate the RCTP Observation Referral to the Clinical Director/Designee Form as recommended. The evaluation will seek to determine if there are opportunities for improvement involving the form itself, the quality of information documented on the form and the logistics of documenting the content of the consultation in an inmate/patient's OMH record.

CQC Reply

CQC acknowledges that the RCTP Observation Referral to the Clinical Director/Designee Form will be standardized and it will continue to be evaluated as recommended.

3. OMH and DOCCS should communicate and document issues or concerns related to the removal of amenities to patients in the RCTP.

DOCCS Response

DOCCS has realized from experience that despite their best efforts in developing items that allow for an inmate's privacy while ensuring they are safe, when their safety is jeopardized, DOCCS' first response is to remove the item and address the risk. This was, as CQC noted, what happened in 2011 when inmates had been able to tear open mattresses and were using them to attempt suicide. We agree any time an item is removed for safety reasons; staff should communicate and document those issues. DOCCS is in the process of developing with OMH a one-day training for RCTP staff. Half of the training will focus on such topics as: cell inspections,

logbook documentation of activities on the unit and supervisor review of entries while on rounds. This recommendation will be included in the training presentation.

OMH Response

The RCTP Monitoring Form which documents the amenities provided to inmate/patients in RCTP Observation Cells is currently being revised in an effort to insure that information regarding amenities is more clearly presented. CNYPC and DOCCS are developing a training program for RCTP staff to be presented during 2013 which will include the importance of documenting clinical and security reasons for removal of any RCTP amenities.

CQC Reply

CQC acknowledges that both OMH and DOCCS have continued to work together to ensure that the RCTP practices regarding provision and removal of amenities is consistent across all RCTP sites and agrees with the planned revision of the RCTP Monitoring Form and training curricula.

APPENDIX 1

In 2010, CQC conducted a systemic review of the RCTP. During this review, CQC conducted private interviews with 52 inmates, and received over 100 surveys from inmates and staff. CQC's recommendations for the 2010 systemic review included;

- OMH and DOCCS would continue to monitor the mental health caseload to ensure that all inmates who have a diagnosis that is defined in the SHU Exclusion Law as a serious mental illness have the required "S" designation,
- DOCS and OMH continue to review and expand the substance abuse treatment programs to ensure that inmates with serious mental illness have timely access to substance abuse treatment, the therapeutic nature of the RCTP would be maximized and decrease the perception that RCTP is punishment by:
 - Ensuring that the restriction and restoration of amenities is based on an individualized assessment of each inmate with an emphasis on the restoration of amenities – especially underwear, clothing and eating utensils, as soon as clinically appropriate;
- Monitoring the temperature in observation cells to ensure that it is comfortable for inmates, especially those in suicide prevention smocks;
- Banning the use of punitive measures, such as using fans as a form of inmate management;
- Ensuring that all corrections officers working in RCTPs, including relief staff, receive the additional mental health training, as required by the SHU Exclusion Law;
- Revise policies and procedures to include transfers from CNYPC or for inmates in need of respite from environmental stressors. CQC recommends that such policies and procedures acknowledge that there may be less risk of self-harm for these inmates and housing and access to amenities should be based on least restrictive principles while they are in the RCTP;
- Improve documentation in:
 - Nursing assessments and progress notes;
 - RCTP monitoring forms; and
 - Consultation with CNYPC for length-of-stay of seven days or more.
- Security log books – clearly identify watches, when mental health staff are on units and document mental health staff review of suicide watch log books; and

- Reconsider the recent OMH decision to identify the reason for transfer on RCTP monitoring forms only in cases of self-harm or assaultive behavior.

CQC's original 2010 report and the agencies responses on the Review of Residential Crisis Treatment Programs can be found in the CQC archives located here: <http://www.justicecenter.ny.gov/commission-quality-care-archives>. The report numbers are FOR001 and FOR002.