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Justice Center for the Protection of People with Special Needs

Forensic Unit Quarterly Report

2nd Quarter 2017

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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 (Chapter 1 of the Laws of 2008) and to monitor the quality of corrections-based mental health care provided to inmate/patients by the Office of Mental Health (OMH) programs operated within the Department of Corrections and Community Supervision (DOCCS).

Background

The SHU exclusion law requires compliance with specific timeframes for providing screenings for risk of suicide for any inmate entering the SHU. In addition, the law requires assessments by mental health staff within statutorily designated timeframes. The timeframes are determined by the type of facility where the SHU is located, with shorter timeframes required for the facilities housing those patient/inmates who require a higher level of mental health care. In addition to determining compliance with the statutorily required timeframes described above, the law requires an evaluation of the quality of care provided to patient/inmates.

What happens on a Justice Center site visit?

Justice Center staff are provided with the census of the unit upon arrival. Size of the units varies greatly with some units having under 20 individuals in the census and others with more than 1,000. Whatever the census, Justice Center staff tour the unit and speak cell-side with every inmate. Once the cell-side tour is complete, Justice Center staff meet and create a list of inmates to privately interview based on observations and comments made cell-side. Justice Center staff also makes referrals to OMH if any inmate appears in need of an assessment by mental health staff. These referrals can be made at the request of the inmate, or upon Justice Center staff's conclusion that such a referral is needed. These referrals, with the details of each inmate's specific need are provided to the mental health unit chief at the time of the visit and followed up in a formal letter to OMH.

Along with cell-side and private interviews, Justice Center staff designates records for inspection. To determine compliance with the timeframes listed in the SHU Exclusion Law, Justice Center staff reviews records on site.[1] In addition to reviewing records for compliance with the statutorily designated timeframes, Justice Center staff compiles a list of records to be produced to review the quality of mental health care (QMHC).[2] Once the records are produced, Justice Center staff requests copies of the clinical documentation, DOCCS guidance records, and DOCCS Sign-In and Unit Activity Log Books to review and ensure that timely and appropriate quality mental health care has been provided in accordance with OMH Policies and Procedures and DOCCS Directives. Following a thorough review, the Justice Center provides detailed findings and recommendations to OMH and DOCCS. Both agencies are provided an opportunity to respond within 30 days.

1 Justice Center staff chose a random sample of records to review for compliance with the required timeframes as follows: units with a census 50 or less, all records are reviewed; units with a census of between 51 and 100, 50% of records are reviewed; units with a census of more than 100, 20% of records are reviewed not to exceed 100 records.
2 Justice Center staff chose a sample of records to review for the quality of mental health care provided as follows: units with a census of 199 or less, 20 records are reviewed; units with a census of 200 or more, 40 records are reviewed.

Quarterly Report: Second Quarter of 2017 (April – June) - The Justice Center Forensic Unit initiated ten Compliance/Quality of Mental Health Care Reviews in the second quarter of 2017; completing 307 cell-side interviews, 50 private interviews,187 compliance reviews, and 148 reviews of the quality of mental health care provided (QMHC).

Quarterly Summary: Second Quarter of 2017 ***Correctional Facility Date of Visit***	***Inmates interviewed cell-side by JC***	***Private Interviews Accepted***	***Inmates referred for immediate action***	***SHU Compliance Reviews Completed***	***Quality of Mental Health Reviews Completed***
Groveland 4/4/2017	13	2	4-Clinician	13	13
Wende 4/5/2017	10	7	1-Clinician 1-Information	10	10
Albion 4/18-4/19/2017	39	6	6-Clinician	37	20
Bedford Hills 5/3/2017	6	2	1-Clinician	6	6
Attica 5/17-5/18/2017	118	11	19-Clinician	26	20
Sing Sing 5/23/17	25	6	7-Clinician	24	20
Shawangunk 5/26/2017	15	5	5-Clinician	14	14
Ulster 5/31/2017	5	0	0	5	5
Washington 6/27/2017	26	4	5-Clinician	20	20
Coxsackie 6/29/2017	50	7	3-Clinician	48	19
Totals	**307**	**50**	**51-Clinician** **1-Information**	**203**	**147**

Inmates Interviewed by the Justice Center: 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.

Private Interviews Accepted: During cell-side interviews, inmates are offered an opportunity to meet privately 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 are provided to the OMH Unit Chief for referrals. 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.

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.

Groveland

Visit Overview: conducted 4/4/2017; 13 cell-side interviews conducted with 2 private interviews accepted; 4 inmates and/or patients referred to a clinician; 13 records reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

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

QMHC Findings/Recommendations and OMH/DOCCS Response:

Justice Center recommended that engagement in private interviews should be encouraged and OMH should document their strategies when an inmate/patient refuses private interviews over an extended amount of time. OMH acknowledged that special attention should be given in documenting strategies used to engage inmate/patients and OMH staff were retrained in Corrections Based Operations Policy #9.30-Progress Notes.

Wende

Visit Overview: conducted on 4/5/2017;10 cell-side interviews conducted with 7 private interviews accepted; 1 inmate and/or patient referred to a clinician; 1 inmate and/or patient referred for additional information about the availability of services at the facility; 10 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

QMHC Findings: 10 records reviewed for quality of mental health care provided with findings of concern identified:

QMHC Findings/Recommendations and OMH/DOCCS Response:

Records reviewed indicated that an inmate/patient was not provided monthly sessions with his primary therapist and progress notes were repetitive and contradictory. OMH acknowledged the need for retraining of Corrections Based Operations Policy #9.30-Progress Notes, specifically time frame requirements and the accuracy of clinical content.

The Justice Center requested an update pertaining to possible psychological testing of an inmate/patient. OMH acknowledged that a referral had been submitted and is being processed for completion.

Following the Justice Center's site visit, two inmate/patients were referred to OMH for follow-up. OMH indicated that they were both seen on April 13, 2017 in response to the referrals. The Justice Center was provided with documentation that the inmate/patients were seen in a May 23, 2017 mailing from OMH.

Albion

Visit Overview: conducted 4/18- 4/19/2017; 39 cell-side interviews conducted with 6 private interviews accepted; 6 inmate and/or patients requested referrals to be seen by a clinician, 37 records reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

QMHC Findings: 20 records reviewed for quality of mental health care provided with findings of concern identified.

QMHC Findings/Recommendations and OMH/DOCCS Response:

The Justice Center requested an update pertaining to a re-evaluation of an inmate/patient's diagnosis referred to in her clinical case record on two occasions. OMH acknowledged that the inmate/patient's clinical case record and psychiatric diagnosis were evaluated.

According to a psychiatric progress note, an inmate/patient was to be evaluated by the psychiatrist again in six weeks. The inmate/patient did not receive a psychiatric call out until almost three months later. OMH indicated that inmate/patients are only required to be seen within 90 days as stated in Corrections Based Operations Policy and not at the request of a psychiatrist. In addition, requests for follow up are reviewed by the Unit Chief and triaged based on the level of need of all CNYPC patients requiring a psychiatric session.

The Justice Center requested any Comprehensive Suicide Risk Assessments (CSRA's) filed on behalf of an inmate/patient that had not been supplied following the site visit. OMH acknowledged that they completed a thorough review and completed updates to the CSRA however did not provide any of the requested assessments or documentary evidence that could be reviewed by the Justice Center.

Bedford Hills

Visit Overview: conducted on 5/3/2017; 6 cell-side interviews conducted with 2 private interviews accepted; 1 inmate and/or patient requested referrals to be seen by a clinician; 6 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

QMHC Findings: 6 records reviewed for quality of mental health care provided with findings of concern identified:

QMHC Findings/Recommendations and OMH/DOCCS Response:

Record Review indicated inconsistent documentation pertaining to an inmate/patient's mental health service level. OMH acknowledged the need for training in Corrections Based Operations Policy #9.12 Treatment Needs/Service Level Designation and #9.7 Chronological Records to ensure accuracy when forms are completed.

The Justice Center found that one inmate/patient was a no-show for three therapist appointments and two psychiatrist appointments without a cell-side contact. OMH retrained staff in Corrections Based Operations Policy #2.4 to ensure that missed appointments are properly followed up and documented by staff.

Attica

Visit Overview: conducted on 5/17- 5/18/2017; 118 cell-side interviews conducted with 11 private interviews accepted; 19 inmate and/or patients requested referrals to be seen by a clinician; 26 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to not be in compliance with the timeframes required by the SHU exclusion law based upon the untimeliness of a DOCCS Suicide Prevention Screening Guidelines form.

QMHC Findings: 20 records reviewed for quality of mental health care provided with findings of concern identified:

QMHC Findings/Recommendations and OMH/DOCCS Response:

Record review indicated that an inmate/patient's Comprehensive Suicide Risk Assessment (CSRA) was not updated to include pertinent information regarding possible suicide risk. OMH asserted in correspondence that they completed a thorough review of the inmate/patient's clinical case record and it was updated to reflect past suicidal gestures. OMH did not provide the Justice Center with any documentary evidence that an update to the record occurred.

Record review revealed that two inmate/patients would be referred for special programming. OMH acknowledged that a review of both inmate/patient's clinical records occurred and one remains stable in general population and the other is currently awaiting placement in the Transitional Intermediate Care Program.

Justice Center requested an update on an inmate who was currently an "active screen" for OMH services. OMH indicated that following the screen process, the inmate did not want mental health services and the clinical assessment determined that he did not require admission to services.

Record reviewed indicated that two inmate/patients were not provided monthly sessions with a primary therapist. OMH reported that they found documentation to support that one inmate/patient was seen monthly and in addition, retrained staff in Corrections Based Operations Policy #9.30-Progress Notes, specifically time frame requirements.

According to a psychiatric progress note, an inmate/patient was to be evaluated by the psychiatrist again within four weeks. OMH asserts that inmate/patients are only required to

be seen within 90 days as stated in Corrections Based Operations Policy and not at the request of a psychiatrist. In addition, requests for follow up are reviewed by the Unit Chief and triaged based on the level of need of all CNYPC patients requiring a psychiatric session.

Record review indicated that Residential Crisis Treatment Program (RCTP) Observation Referral to Clinical Director/Designee Notes were not completed per policy. OMH staff were retrained in Corrections Based Operations Policy #9.30-Progress Notes with special attention to the RCTP Observation Referral to Clinical Director/Designee Note.

Inmate/patient was a Mental Health Service Level 1S and pending a disciplinary hearing at the time of the Justice Center's site visit. DOCCS responded to the Justice Center that the inmate/patient in question was moved to the Intermediate Care Program after his disciplinary hearing process.

Record review revealed that an inmate/patient was denied a DOCCS escort to programming due to wearing a sweatshirt. DOCCS indicated that all inmates must be dressed in state greens for movement and programming. All inmates are made aware of this during orientation and staff make rounds to notify that program movement is about to begin.

Sing Sing

Visit Overview: conducted on 5/23/2017; 25 cell-side interviews conducted with 6 private interviews accepted; 7 inmate and/or patients requested referrals to be seen by a clinician; 24 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

QMHC Findings: 20 records reviewed for quality of mental health care provided with findings of concern identified:

QMHC Findings/Recommendations and OMH/DOCCS Response:

Records reviewed indicated contradictory information pertaining to suicide risk and warning signs. OMH indicated OMH staff were retrained in Corrections Based Operations Policy #9.22 – Treatment Plan and #9.30-Progress Notes to ensure accuracy when forms are completed and updated.

The clinical case record of one inmate/patient indicated that his psychiatric diagnosis would be re-evaluated. OMH declined to respond to the Justice Center's recommendation of requesting an update pertaining to an evaluation of the inmate/patient's diagnosis, citing their requirement "to insure the confidentiality of our clinical records and patients' private health information."

The Justice Center found that one inmate/patient did not receive three scheduled call outs with the psychiatrist due to "scheduling and movement issues." DOCCS responded in writing to the Justice Center and indicated that they control movement in the correctional facilities. They stated that the facility considers that all OMH call outs are mandatory and are listed on the daily call out sheet that is dispersed throughout the facility.

Record review indicated that an inmate/patient's current status would be reviewed at the Joint Case Management Committee (JCMC) meeting.[1] DOCCS supplied the Justice Center with all JCMC minutes pertaining to the inmate/patient in question.

Record review found that an outdated version of the DOCCS Mental Health Referral was being used. DOCCS re-issued a memo instructing the replacement of the old Mental Health Referrals forms and to immediately remove all old forms.

Shawangunk

Visit Overview: conducted on 5/26/2017; 15 cell-side interviews conducted with 5 private interviews accepted; 5 inmate and/or patients requested referrals to be seen by a clinician; 14 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

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

QMHC Findings/Recommendations and OMH/DOCCS Response:

Records reviewed indicated multiple SHU Mental Health Interviews were completed on the same day, at the same time, by the same clinician. OMH insisted that the times noted on the clinical documents were incorrect. OMH staff members were retrained in Corrections Based Operations Policy #9.29 – Special Housing Unit/Long Term Keeplock Mental Health Assessment to ensure the proper documentation of the time spent with inmate/patients during clinical contacts.

Justice Center found that only one inmate/patient accepted a private interview for their SHU Mental Health Interview. Although OMH documented refusals and provided a brief reason, interviews were declined 28 of 29 occasions. OMH reported that seven inmates were not on the caseload at the time and may not warrant private interviews. However, the OMH Forensic Program Administrator conducted a review with staff specific to the issue of documentation within progress notes, with special attention given to the importance of documenting strategies utilized to engage inmate/patients.

Ulster

Visit Overview: conducted on 5/31/2017; 5 cell-side interviews conducted with no private interviews accepted; 5 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

QMHC Findings: 5 records reviewed for quality of mental health care provided with no findings of concern identified.

[1] DOCCS Directive #4933A – Joint Case Management Committee – The purposes of the Joint Case Management Committee are to review, monitor, and coordinate the behavior and treatment plans for inmates.

Washington

Visit Overview: conducted on 6/27/2017; 26 cell-side interviews conducted with 4 private interviews accepted; 5 inmate and/or patients requested referrals to be seen by a clinician; 20 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to be in compliance with the timeframes required by the SHU exclusion law.

QMHC Findings: 20 records reviewed for quality of mental health care provided with findings of concern identified:

QMHC Findings/Recommendations and OMH/DOCCS Response:

The Justice Center found that one inmate/patient did not receive a scheduled call out following a mental health referral due to "no escort available at this time." Although rescheduled, the next appointment was cancelled due to "staff cancellation." OMH retrained staff members in Corrections Based Operations Policy #2.4-Canceled/Refused/Missed Call outs and will closely monitor staff to ensure that this does not happen again. DOCCS acknowledged that mental health call outs are mandatory. Inmates assigned to the special housing unit are escorted to all mandatory call-outs.

Records review indicated that inmate/patients were not provided monthly sessions with their therapist. OMH retrained staff members in Corrections Based Operations Policy #9.30 Progress Notes and will closely monitor staff to ensure no more occurrences.

Two inmate/patients were not seen by a therapist within two weeks of their transfer to the facility. OMH retrained staff members in Corrections Based Operations Policy #7.2-Active Transfers and will closely monitor staff to ensure no more occurrences.

Following the Justice Center's site visit, five inmates and/or patients were referred to OMH to be seen with detailed reasons for their referral, including medication concerns, symptoms of helplessness, and increased anxiety. The Justice Center requested that OMH provide documentation that these inmate/patients were seen and received appropriate treatment. OMH stated that the inmates and/or patients were all seen as clinically appropriate. The Justice Center was unable to review documents to confirm this statement because OMH made them available for review only at the Central New York Psychiatric Center in Marcy, NY.

Coxsackie

Visit Overview: conducted on 6/29/2017; 50 cell-side interviews conducted with 7 private interviews accepted; 3 inmate and/or patients requested referrals to be seen by a clinician; 48 records were reviewed for compliance with the timeframes required in the SHU exclusion law.

Compliance Findings: Facility determined to not be in compliance with the timeframes required by the SHU exclusion law based upon untimeliness of DOCCS Suicide Prevention Screening Guidelines forms and OMH assessments.

Quality of Care Review Findings: 19 records reviewed for quality of mental health care provided with findings of concern identified:

QMHC Findings/Recommendations and OMH/DOCCS Response:

Records reviewed indicated that an inmate/patient was not provided monthly sessions with his therapist. OMH did not respond to the Justice Center's October 6, 2017 letter of findings within 30 days. [2]

Justice Center found that only four inmate/patients accepted a private interview for their SHU Mental Health Interview during the review period. In total, 54 out of 69 private interviews were declined. OMH did not respond to the Justice Center's October 6, 2017 letter of findings within 30 days. [3]

[2] No response was received by November 6, 2017, the deadline for a response.
[3] No response was received by November 6, 2017, the deadline for a response.