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Justice Center for the Protection of People with Special Needs

Forensic Unit Quarterly Report

4th Quarter 2018

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Report: Fourth Quarter of 2018 (October - December)
The Justice Center Forensic Unit initiated 6 SHU Compliance/Quality of Mental Health Care Reviews in the fourth quarter of 2018; completing 144 cell-side interviews, 14 private interviews, 121 compliance reviews, and 91 reviews of the quality of mental health care provided (QMHC).

Quarterly Summary: Fourth Quarter of 2018 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***
Coxsackie CF – 10/1/2018	38	8	5 - Clinician	38	20
Washington CF–10/4/2018	32	1	2-Clinician	23	23
Woodbourne CF – 10/19/2018	9	0	0	8	8
Eastern CF – 10/24/2018	12	0	0	9	9
Albion CF – 10/29/2018	42	4	9-Clinician	32	20
Wende CF – 10/30/2018	11	1	1-Clinician	11	11
Totals	**144**	**14**	**17-Clinician**	**121**	**91**

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[1].

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.

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

SHU Compliance Findings Summary of Issues Found at More than One Correctional Facility:

5 out of the 6 facilities visited were in compliance with the timeframes contained in the SHU Exclusion Law. The one facility that was not in compliance did not clearly indicate how long inmate/patients were on Exceptional Circumstances, whether they were reviewed every fourteen days, when they were removed, or when they transferred to a special program.[2]

Two of the six facilities visited had inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and inmate/patients on Exceptional Circumstances in SHU at the time of the Justice Center visit. In total there were 6 inmate/patients who met the definition of serious mental illness and 8 inmate/patients on Exceptional Circumstances at the two facilities.

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

- Inmate/patients were not assessed by psychiatric staff according to policy (2 facilities)
- Inmate/patients were not able meet with clinical mental health staff monthly according to policy (3 facilities)
- There were no issues or concerns related to the quality of mental health care at 3 facilities

Findings at Individual Correctional Facilities:

Coxsackie CF

Visit Overview: conducted 10/1/2018; 38 cell-side interviews conducted with 8 private interviews accepted; 5 inmates referred to a clinician; 38 records 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: Facility determined to be in compliance with the timeframes required by the SHU Exclusion Law.

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

QMHC Findings/Recommendations and OMH/DOCCS Response:

[2] Seriously Mentally Ill (SMI) inmates may be placed on Exceptional Circumstances when they pose an unacceptable risk to the safety and security of staff and inmates in out of cell programming. This may include restrictions on property, services and privileges. Inmates will be provided alternative mental health treatment and the Exceptional Circumstances placement is reviewed every fourteen days by the treatment team.

It was documented by OMH staff that multiple inmate/patients were unable to meet with psychiatric staff due to "DOCCS security issues." The Justice Center requested an explanation as to why the inmate/patients were not able to attend their private call out. DOCCS responded that there were no reported instances of "security issues" that took place on those days that would suggest that an OMH call out could not take place. DOCCS also further stated that the October 2018 Memorandum from DOCCS stating that mental health call outs should be considered mandatory was re-issued at the Coxsackie CF and that the Deputy Superintendent for Security would re-iterate that OMH call outs are mandatory at the next supervisory meeting.

At the time of the Justice Center's site visit, an inmate was considered a Mental Health Service Level 4 – Active Screen. The Justice Center requested an update as to whether the inmate was admitted to the mental health caseload. OMH stated in their response that the inmate remained on active status for almost two months following the site visit and was not admitted to the caseload because his symptoms appeared to have resolved.

There was no documentary evidence that three inmate/patients were seen monthly or following their transfer as required by OMH policy. It was recommended that OMH clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes and that the Unit Chief should complete quality assurance checks to ensure that inmate/patients are seen as required by policy. OMH forwarded documentation to support that one inmate/patient had been seen on a monthly basis to the Justice Center and OMH acknowledged that the other two inmate/patients had not been seen in accordance to policy. Policy #9.30 – Progress Notes was reviewed with all clinical staff.

An inmate/patient's Chronological Record Form did not include his most recent Mental Health Service Level or his court trips. The Justice Center recommended that OMH retrain clinical staff in CNYPC CBO Policy #9.7 Chronological Record Form. In addition, the OMH Unit Chief should complete quality assurance checks to ensure that all information is being recorded properly. OMH indicated that all clinical staff reviewed CNYPC CBO Policy #9.7 Chronological Record Form.

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 correctional facility being reviewed. The findings below pertain to correctional facilities other than Coxsackie CF:

- An inmate/patient was not seen by mental health staff according to policy at the Eastern CF. The Justice Center requested that OMH clinical staff at the Eastern CF be retrained in CNYPC CBO Policy #9.30 – Progress Notes and that the Unit Chief should complete quality assurance checks to ensure that inmate/patients are monitored in the required time frame. OMH acknowledged that there was documentation to support that the inmate/patient had been seen on a monthly basis while at the Eastern CF and the documentation was forwarded in OMH's response to the Justice Center.

- While at the Downstate CF, a SHU/LTKL Mental Health Interview had not been conducted per policy. The Justice Center requested an explanation as to why the inmate/patient was not able to be assessed in the appropriate time frames. OMH replied that the inmate/patient in question had been moved off the unit in preparation for transfer, therefore OMH was unable to conduct a call out for assessment.

- An inmate/patient at the Five Points CF was unable to be assessed by psychiatric staff per policy following their admission to mental health services. It was requested that the OMH Unit Chief conduct quality assurance checks to ensure that inmate/patients are monitored in the appropriate time frame. In addition, OMH psychiatric staff should be retrained in CNYPC CBO Policy #9.27 – Psychiatric Progress Notes.

Washington CF

Visit Overview: conducted on 10/4/2018; 32 cell-side interviews conducted with no private interviews accepted; 2 inmates and/or patients were referred to a clinician; 23 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: Facility determined to be in compliance with the timeframes required by the SHU Exclusion Law.

QMHC Findings: 23 records reviewed for quality of mental health care.
No issues or concerns related to the quality of mental health care provided to the inmates and/or patients at the Washington CF were found as a result of the Justice Center's record review.

Woodbourne CF

Visit Overview: conducted on 10/19/2018; 9 cell-side interviews conducted with 0 private interviews accepted; 0 inmates and/or patients referred to a clinician; 8 records were reviewed for compliance within 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: Facility determined to be in compliance with the timeframes required by the SHU Exclusion Law.

QMHC Findings: 8 records reviewed for quality of mental health care provided. No issues or concerns related to the quality of mental health care provided to the inmates and/or patients at the Woodbourne CF were found as a result of the Justice Center's record review.

Eastern CF

Visit Overview: conducted on 10/24/2018; 12 cell-side interviews conducted with 0 private interviews accepted; 0 inmate and/or patient referred to a clinician; 9 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: Facility determined to be in compliance with the timeframes required by the SHU Exclusion Law.

QMHC Findings: 9 records reviewed for quality of mental health care provided. No issues or concerns related to the quality of mental health care provided to the inmates and/or patients at the Eastern CF were found as a result of the Justice Center's record review.

Albion CF

Visit Overview: conducted on 10/29/2018; 42 cell-side interviews conducted with 4 private interviews accepted; 9 inmates and/or patients referred to a clinician; 32 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were 5 inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and 1 inmate/patient on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: It was determined that the facility was 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 below:

QMHC Findings/Recommendations and OMH/DOCCS Response:

An inmate/patient's clinical case record indicated that the Referral to the Clinical Director/Designee was not completed every seven days as required by policy while the inmate/patient was in the Residential Crisis Treatment Program (RCTP). The Justice Center requested that OMH clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes, specifically the section pertaining to the RCTP Observation Referral to the Clinical Director/Designee. In addition, it was recommended that the Unit Chief complete quality assurance checks to ensure that all RCTP documentation is thoroughly completed. OMH retrained their clinical staff in CNYPC CBO Policy #4.0 – RCTP Observation Cells, because it specifically addresses the documentation expectations for patients admitted to the RCTP.

One inmate/patient was not provided monthly sessions with a primary therapist and did not attend group therapy. The Justice Center requested clarification as to whether a group therapy appointment is considered a missed call out and if so, then OMH clinical staff should be trained in both CNYPC CBO Policy #2.4 Canceled/Refused/Missed Callouts and CNYPC CBO Policy #9.30 – Progress Notes. OMH noted that all clinical staff were retrained in CNYPC CBO Policy #9.30 – Progress Notes. OMH indicated that both policies would apply in this inmate/patient's case because group therapy sessions in General Population are synonymous with monthly callouts. Therefore, both policies were reviewed with the clinical staff as per the Justice Center's recommendation.

Two DOCCS Suicide Prevention Screening Guideline Forms were found to incorrectly identify the type of mental health referral warranted. The Justice Center recommended that DOCCS assess how to ensure that facility staff are appropriately utilizing referrals to mental health staff as instructed. DOCCS responded that the appropriate completion of the Suicide Prevention Screening Guidelines Form was addressed with the Facility Superintendent and all suitable staff, including Lieutenants and Captains, were trained on how to complete the form accurately.

Wende CF

Visit Overview: conducted on 10/30/2018; 11 cell-side interviews conducted with 1 private interview accepted; 1 inmate and/or patient referred to a clinician; 11 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There was one inmate/patient who met the SHU Exclusion Law criteria for the definition of serious mental illness and 7 inmate/patients on Exceptional Circumstances during the Justice Center's review period.

Compliance Findings: Facility determined to not be in compliance with the SHU Exclusion Law as Exceptional Circumstances documentation did not clearly indicate how long inmate/patients were on Exceptional Circumstances, whether they were reviewed every fourteen days, when they were removed, or when they transferred to a special program. The Justice Center recommended that OMH and DOCCS work collaboratively and develop a standardized method of determining when documentation is reviewed, its accuracy, and clarity. OMH deferred to DOCCS noting that DOCCS is responsible for the review and maintenance of records related to all cases of Exceptional Circumstances. DOCCS acknowledged that there was not documentation that the case in question had been reviewed every fourteen days. In addition to addressing the documentation concerns with facility staff immediately, the Assistant Deputy Superintendent for Correctional Mental Health facilitated a training on the appropriate utilization of the form.

QMHC Findings: 11 records reviewed for quality of mental health care provided with findings of concern identified below:

QMHC Findings/Recommendations and OMH/DOCCS Response:

An inmate/patient on Exceptional Circumstances was scheduled to be reviewed following the Justice Center's site visit. The Justice Center asked for an update after the visit to find out if the inmate/patient remained on Exceptional Circumstances or had been transferred to a special program. OMH deferred to DOCCS noting that the inmate/patient had been transferred to a Residential Mental Health Unit program. DOCCS indicated that the inmate/patient had been evaluated in the appropriate time frame and had been transferred to a special program.

Two inmate/patients were not seen by mental health staff or rescheduled when their callouts were missed per policy. The Justice Center recommended that mental health staff be retrained in both CNYPC CBO Policy #2.4 Canceled/Refused/Missed Callouts and CNYPC CBO Policy #9.30 – Progress Notes to ensure that inmate/patients are seen in a timely manner and that the OMH Unit Chief should also complete quality assurance checks. In addition, when inmate/patients consistently refuse mental health treatment, both DOCCS and OMH staff should develop an individualized plan to encourage participation in treatment. OMH reported that one inmate/patient had been seen during the appropriate time frame and provided documentary evidence with their response. Due to the concerns noted with the second inmate/patient, OMH staff were retrained in CNYPC CBO Policy #2.4 Canceled/Refused/Missed Callouts.

On two separate occasions, it was unclear when an inmate/patient was discharged from the Residential Crisis Treatment Program (RCTP) therefore, it is unknown if he was evaluated by a psychiatrist in the appropriate time frame. Documentation was requested by the Justice Center as to whether the inmate/patient had been evaluated by psychiatric staff prior to his discharge from the RCTP, and to determine what his actual discharge date was. OMH provided the date

that the inmate/patient was discharged from the RCTP and all the supporting documentation with their response.

An inmate/patient clinical case record indicated that he had been referred to the Correctional Alternative Rehabilitation (CAR) Program.[3] In response to the Justice Center's request for an update on this referral, OMH reported that the inmate/patient had been admitted to the CAR program and then returned to general population.

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 correctional facility being reviewed. The findings below pertain to correctional facilities other than Wende CF:

- While at the Marcy CF RMHU, an inmate/patient was not rescheduled to meet with psychiatric staff per policy after he refused to attend a callout. The Justice Center requested that OMH psychiatric staff be retrained in CNYPC CBO Policy #2.4 Canceled/Refused/Missed Callouts and CNYPC CBO Policy #9.27 – Psychiatric Progress Notes. In addition, the OMH Unit Chief should complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. OMH acknowledged that CNYPC is working on restructuring Video Teleconferencing (VTC) to ensure that patients have greater access to psychiatric staff and that follow up to canceled/refused/missed callouts is consistently provided.

- It could not be determined if an inmate/patient was assessed by mental health in the appropriate time frame upon admission to the SHU at the Five Points CF. The Justice Center requested clarification and recommended that OMH staff at the Five Points CF be retrained in the designated time frames regarding the SHU/LTKL Mental Health Interviews and appropriate documentation of information on the Chronological Record as his admission to SHU was not indicated on the form. OMH stated that the inmate/patient was considered in transit and had an overnight at the Downstate CF, therefore, his SHU/LTKL Mental Health Interview was completed within one business day of his entrance to the SHU.

- While at the Great Meadow CF, an inmate/patient was not assessed by mental health staff in the appropriate timeframe for a SHU/LTKL Mental Health Interview. The Justice Center recommended that OMH staff at the Great Meadow CF be retrained in the designated time frames regarding the SHU/LTKL Mental Health Interviews. OMH indicated that the inmate/patient was considered in transit and had an overnight at the Downstate CF, therefore, his SHU/LTKL Mental Health Interview was completed within one business day of his entrance to the SHU.

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Summary of Mental Health Service Review Findings

The Justice Center completes a six-month review of the quality of mental health care for all inmate/patients who commit suicide while on the mental health caseload.
Four mental health service reviews were initiated during this quarter at the Coxsackie CF, Mid-State CF, Attica CF, and Auburn CF.

[3] CAR addresses the special needs of inmates with intellectual and adaptive deficits who are serving disciplinary sanctions in SHU.

Mental Health Service Review Findings Summary of Issues Found at More than One Correctional Facility

- RCTP Observation/Referral's to the Clinical Director/Designee were not completed according to policy at 2 facilities.

Coxsackie CF

The Justice Center found that there was inconsistent documentation regarding the inmate/patient's mental health diagnosis, repetitive group therapy progress notes and clinical documentation that was not completed in a timely and accurate manner. It was requested that all clinical staff be retrained in CNYPC CBO Policy #9.30 Progress Notes, CBO Policy #9.10 Diagnosis Record and CBO policy #9.70 Chronological Record. OMH acknowledged that they retrained all requested policies with clinical staff at the Coxsackie CF.

Mid-State CF

The Justice Center found that OMH failed to recognize the suicide risk factors and warning signs displayed by the inmate/patient. It was recommended that the OMH Clinical Director or Regional Psychiatrist complete a comprehensive review of the mental health treatment leading up to the inmate/patient's death, including the appropriateness of the psychiatric medications administration practices and the clinical care provided to an individual with a history of suicide attempts, substance abuse and chronic/acute suicide risk factor and warning signs.

OMH responded by saying that both the CBO Clinical Director and the regional consulting psychiatrist reviewed the inmate/patient's case and did not agree with the Justice Center's findings that OMH failed to recognize the suicide risk factors and warning signs displayed. According to OMH, the inmate/patient's medications were monitored during call outs and despite medication changes made in response to the inmate/patient and education regarding the use of Suboxone, his medications had to be discontinued due to drug use. In addition, OMH noted that through ongoing and thorough clinical assessment, it was determined that the inmate/patient did not meet the criteria for acute crisis intervention services, never threatened to harm himself or others, nor did he display self-harming behaviors indicating imminent risk.

Attica CF

The Justice Center's review found deficiencies regarding the provision of timely access to mental health services, lack of documentation and minimal evidence that additional support or alternative treatment measures were offered to combat the inmate/patient's disengagement with treatment, continued endorsement of suicidal ideation and continued engagement in suicidal gestures/attempts. The Justice Center recommended that the Regional Psychiatrist or Clinical Director complete a comprehensive review of six months leading up to the inmate/patient's suicide. OMH responded that as a result of their Incident Review Committee recommendations, additional conferences occurred with administration and OMH staff and that Great Meadow CF clinical staff and designated OMH leadership will start conducting case reviews to ensure ongoing compliance with call outs and completion of appropriate documentation.

According to the inmate/patient's clinical case record, he had been accepted to transfer to CNYPC, however, had still not been transferred at the time of his death. The Justice Center

requested an update on efforts being made to move individuals to CNYPC in a timely manner. OMH responded that all individuals are reviewed on a weekly basis while awaiting transfer and that prior to inpatient admission, inmate/patients are monitored in the RCTP and receive daily clinical assessment and treatment and designated safety precautions.

The Justice Center's record review found that RCTP Observation Referrals to the Clinical Director/ Designee Notes were not completed at two correctional facilities. It was requested that OMH staff members at both the Great Meadow CF and Attica CF be retrained in CNYPC CBO Policy #4.0 – RCTP Observation Cells and the Unit Chief should complete quality assurance checks to ensure that all RCTP documentation is thoroughly completed. OMH responded that the RCTP Observation Referrals to the Clinical Director/ Designee Notes for the Attica CF were completed per policy, just not filed in the inmate/patients sealed OMH record prior to the submission to the Justice Center. OMH clinical staff at the Great Meadow CF were retrained in CNYPC CBO Policy #4.0 – RCTP Observation Cells.

The inmate/patients clinical record also noted that he had not been seen by clinical staff or psychiatric staff according to policy while in the RCTP at the Great Meadow CF. In addition, The Justice Center recommended that clinical OMH staff be retrained in CNYPC CBO Policy #9.30 Progress Notes and psychiatric staff in CNYPC CBO Policy #4.0 – RCTP Observation Cells & Dormitory Beds and CNYPC CBO Policy #9.27 – Psychiatric Progress Notes. OMH acknowledged the finding and reported that the Policy #9.30 was reviewed with the Great Meadow CF treatment team.

Auburn CF

The Justice Center's review found little evidence that OMH or DOCCS made any effort to provide additional support or offer alternative treatment measures to combat the inmate/patient's disengagement with treatment, medication noncompliance, continued endorsement of suicidal ideation and engagement in suicidal gestures. Per documentation received, there was no evidence that an RCTP Observation/Referral to the Clinical Director/Designee was completed during an RCTP stay. The Justice Center requested that OMH staff be retrained in CNYPC CBP Policy #4.0 – RCTP Observation Cells. OMH acknowledged that they also identified this issue and reviewed the coordinating CBO Policy with clinical staff.

A "clinical referral for consultation was submitted to the CNYPC Team" because the inmate/patient had an extensive clinical history, including suicidal ideation and attempts. It was unclear if the referral to CNYPC was made on the inmate/patient's behalf. The Justice Center recommended that the Clinical Director complete a comprehensive review of the inmate/patient's mental health care leading up to his suicide. OMH reported that the referral to the CNYPC team was not a referral to inpatient care, it was a referral to the Clinical Director/Designee and Psychologist consultant. In reviewing the mental health care provided, OMH indicated that the treatment team continued to monitor the inmate/patient treatment needs and determined that he was making progress towards stabilization and reporting future orientation, therefore, he did not meet the criteria for inpatient psychiatric admission.

The inmate/patient's clinical case record indicated that he was not assessed by mental health prior to a discharge from the infirmary. The Justice Center requested an explanation as to why a referral to mental health was not initiated and any directive pertaining to mental health training provided to medical staff. DOCCS indicated that all staff receive mandatory training annually on

suicide prevention. In addition, OMH provides annual training to all PEF employees that do not work in mental health programs, on recognizing the signs and symptoms of mental illness.