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Justice Center for the Protection of People with Special Needs

# SHU Exclusion Monitoring Report

## 1st Quarter 2019

November 2019

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

**Report: First Quarter of 2019 (January – March)**
The Justice Center initiated four SHU Compliance/Quality of Mental Health Care Reviews in the first quarter of 2019; completing 145 cell-side interviews, 16 private interviews, 89 compliance reviews, and 52 reviews of the quality of mental health care provided (QMHC).

| ***Quarterly Summary: First Quarter of 2019 Correctional Facility Date of Visit*** | ***Inmates interviewed cell-side by Justice Center*** | ***Private Interviews Accepted*** | ***Inmates referred for immediate action*** | ***SHU Compliance Reviews Completed*** | ***Quality of Mental Health Reviews Completed*** |
|---|---|---|---|---|---|
| Bedford Hills TBU – 1/23/2019 | 7 | 2 | 0 | 7 | 7 |
| Marcy RMHU – 2/19-20/2019 | 93 | 6 | 6 | 43 | 20 |
| Mohawk CF – 2/26/2019 | 40 | 6 | 11 | 32 | 20 |
| Sullivan CF – 3/26/2019 | 5 | 2 | 1 | 7 | 5 |
| ***Totals*** | **145** | **16** | **18** | **89** | **52** |

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 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.

[1] NYS Correction Law Section 401 (a)

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

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

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

Three out of the four 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 that two inmate/patients on Exceptional Circumstances were reviewed every fourteen days.[3]

Three of the four facilities visited had inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness as well as inmate/patients on Exceptional Circumstances in SHU at the time of the Justice Center visit. In total, there were 101 inmate/patients who met the definition of serious mental illness and 63 inmate/patients on Exceptional Circumstances at the three facilities visited during the first quarter of 2019.

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

- 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). (Two facilities)
- Inmate/patients were not seen monthly or upon transfer by their primary therapist as required by OMH policy (Four facilities)
- Inmate/patients were not assessed by psychiatric staff according to policy (Two facilities)

**Findings at Individual Correctional Facilities:**

**Bedford Hills CF TBU**

*Visit Overview*: conducted January 23, 2019; seven cell-side interviews conducted with two private interviews accepted; no inmates were referred to a mental health clinician; seven records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were seven inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and six 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.

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

[3] 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.

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

*QMHC Findings/Recommendations and OMH/DOCCS Response:*

The Justice Center's review found that 54 percent of the Informational Reports completed were positive and demonstrated positive feedback to inmate/patients. It was determined that 83 percent were completed by DOCCS and 17 percent were completed by OMH. The Justice Center requested that the purpose of the Informational Report be reviewed with OMH staff. In addition, the Justice Center recommended that OMH consider creating a policy related to the purpose and procedures for writing an Informational Report. OMH acknowledged that the 2018 Residential Mental Health Treatment Unit statewide training paid special attention to the purpose and procedure of the Informational Report and all Bedford Hills staff participated in the training. OMH stated that they would monitor relevant data related to the OMH completion of the Informational Report to determine the need for further staff development.

An inmate/patient's clinical case record indicated that the RCTP Observation Referral to the Clinical Director/Designee was not completed every seven days as required by policy while the inmate/patient was in the 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 reviewed CNYPC CBO Policy #4.0 – RCTP Observation Cells with clinical staff and indicated that quality assurance checks are occurring regularly.

There was no documentary evidence that an inmate/patient was seen monthly with her primary therapist as required by OMH policy. It was recommended that OMH clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes and Policy #2.4 – Canceled/Refused/Missed Callouts. In response, OMH reviewed CNYPC CBO Policy #9.30 – Progress Notes with all clinical staff.

**Marcy CF Residential Mental Health Unit (RMHU)**

*Visit Overview:* conducted on February 19, 2019 and February 20, 2019; 93 cell-side interviews conducted with 6 private interviews accepted; 6 inmates/patients were referred to a mental health clinician; 43 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were 93 inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and 43 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:* Twenty records reviewed for quality of mental health care with findings of concern identified below.

*QMHC Findings/Recommendations and OMH/DOCCS Response:*

It was determined that 49 percent of the Informational Reports completed between January and February 2019 were positive and during the Justice Center's review period the Marcy RMHU approved 2,628 days of time cuts for the 20 inmates whose records were reviewed.

Documentation errors were found on Exceptional Circumstances paperwork which would have led to the facility not being in compliance had Justice Center staff not asked for additional documentation to clarify that placement was in fact reviewed every fourteen days. It was requested that DOCCS assess how best to ensure that the review and removal date of Exceptional Circumstances is clearly documented on the form. DOCCS responded that a memo would be sent out to all facilities with a Residential Mental Health Treatment Unit reminding them of the requirement to review all Exceptional Circumstances within 14 days.

An inmate/patient's clinical case record indicated that the RCTP Observation 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 and/or CNYPC CBO Policy #4.0 – RCTP Observation Cells. In addition, it was recommended that the Unit Chief complete quality assurance checks to ensure that all RCTP documentation is thoroughly completed. OMH reviewed CNYPC CBO Policy #4.0 – RCTP Observation Cells with all clinical staff.

Four inmate/patient's Chronological Record Forms were not updated in accordance with CNYPC CBO Policy #9.7 Chronological Record Form. The Justice Center recommended that OMH retrain clinical staff in CNYPC CBO Policy #9.7 Chronological Record Form and OMH indicated that all staff responsible for updating the Chronological Records reviewed the policy.

An inmate/patient did not meet with psychiatric staff per policy after he transferred to the Marcy RMHU. The Justice Center requested that OMH psychiatric staff be retrained in CNYPC CBO Policy #9.27 – Psychiatric Progress Notes to confirm notes are completed in the appropriate time frame. OMH acknowledged that a callout had been scheduled but was missed, therefore they retrained psychiatric staff in both CNYPC CBO Policy #9.27 – Psychiatric Progress Notes and CNYPC CBO Policy #2.4 Canceled/Refused/Missed Callouts. In addition, OMH also supplied the Justice Center with a psychiatric progress note indicating the inmate/patient had been seen by psychiatric staff, just not in the appropriate time frame.

There was no documentary evidence that four inmate/patients were seen monthly by their primary therapists at the Marcy RMHU and the Great Meadow CF as required by OMH policy. It was recommended that OMH clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes to ensure notes are completed and time frames adhered to. OMH acknowledged that Policy #9.30 – Progress Notes was reviewed with all clinical staff at the Marcy RMHU and the clinician assigned to one of the inmate/patients during his time at the Great Meadow CF. OMH further noted that a review could not take place with another assigned clinician as the staff person is no longer employed by CNYPC.

*A six-month review of DOCCS and OMH records often includes records of treatment that an inmate/patient received at another correctional facility before being transferred to the correctional facility reviewed. The findings below pertain to correctional facilities other than the Marcy RMHU:*

- While at the Attica CF, an inmate/patient did not receive his initial and 14-day SHU/LTKL Mental Health Assessments in the appropriate timeframe. The Justice Center recommended that OMH evaluate how to ensure that clinical staff provide timely assessments at the Attica CF and that may include retraining in CNYPC CBO Policy #6.0 - Special Housing Unit Services in MHSL 1 Facilities. OMH indicated that Policy #6.0 - Special Housing Unit Services in MHSL 1 Facilities was reviewed with the Attica CF SHU Coordinator.

**Mohawk CF**

*Visit Overview*: conducted on February 26, 2019; 40 cell-side interviews conducted with six private interviews accepted; 11 inmates and/or patients were referred to a mental health clinician; 32 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:* Twenty records reviewed for quality of mental health care provided with findings of concern identified below.

*QMHC Findings/Recommendations and OMH/DOCCS Response:*

According to an inmate/patient's OMH clinical record, following his transfer to the Coxsackie CF, he reported that he did not receive his prescribed medications. It was documented that the clinician learned from the medical RN the inmate/patient had refused his medication although the inmate/patient continued to report that he wasn't being offered them. Psychiatric staff also indicated that the treatment team would submit a medication error form to DOCCS. The Justice Center requested an explanation or evidence of any corrective actions pertaining to whether or not the inmate/patient was provided his medications. OMH deferred the response to DOCCS and DOCCS responded that according to their records the inmate/patient had received his medications and provided documentation indicating such.

An inmate/patient's psychotropic medications were discontinued after three days of refusal. The Justice Center found the process by which medications are discontinued after a certain amount of refusals disconcerting and requested an update pertaining to the inmate/patient in question, specifically when he was meeting with psychiatric staff and whether medications were prescribed. In addition, the Justice Center requested the policy pertaining to medication refusals and the discontinuation of psychotropic medications. OMH provided the Justice Center the dates the inmate/patient had the opportunity to meet with psychiatric staff and that he was taking medications again. CNYPC CBO Policy #3.8 - Medication not Administered/Returned to the Nurses Station was forwarded with OMH's response. OMH also acknowledged that the policy was reviewed with the prescriber responsible for prescribing medications to the inmate/patient during the review period.

There was no documentary evidence that multiple inmate/patients were seen monthly by their primary therapists or upon transfer as required by OMH policy. It was recommended that OMH clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes to ensure notes are

completed and time frames adhered to and that the Unit Chief complete quality assurance checks to ensure proper monitoring. OMH indicated that all clinical staff reviewed CNYPC CBO Policy #9.30 – Progress Notes and the Unit Chief will continue to complete checks of the internal CNYPC database to ensure that patients are scheduled and seen per policy.

Clinical records indicated that one inmate/patient was not seen by mental health when he transferred from the Mid-State CF mid-month to the Mohawk CF. The Justice Center requested that clinical staff at the Mohawk CF be retrained in CNYPC CBO Policy #9.30 – Progress Notes however upon OMH's review, they opined that because the inmate/patient was housed in the SHU, a review of CNYPC CBO Policy #9.29 – Special Housing/Long Term Keep Lock Mental Health Interview was more appropriate and a review was completed with the Midstate CF SHU Coordinator.

There was no clinical documentation to support that an inmate/patient was seen by psychiatric staff following two different facility transfers. It was recommended that OMH psychiatric staff at the Upstate and Mohawk CF's be retrained in CNYPC CBO Policy #9.27 – Psychiatric Progress Notes. In addition, the Unit Chief should complete quality assurance checks to ensure inmate/patients are monitored in the appropriate time frame. OMH responded that due to the fact that the inmate/patient was scheduled to be seen but missed his psychiatric callout, CNYPC CBO Policy #9.24 – Cancelled/Refused/Missed Callouts was reviewed with the psychiatrist that was originally scheduled to see the inmate/patient.

*A six-month review of DOCCS and OMH records often includes records of treatment that an inmate/patient received at another correctional facility before being transferred to the correctional facility reviewed. The findings below pertain to correctional facilities other than the Mohawk CF:*

- There was no evidence that an inmate/patient was rescheduled to see the psychiatrist while at the Downstate CF according to policy CNYPC CBO Policy #9.24 – Cancelled/Refused/Missed Callouts. The Justice Center requested that OMH psychiatric staff at the Downstate CF be retrained in CBO Policy #9.24, specifically that they should be seen cell side if they miss their callout. In addition, the Unit Chief should complete quality assurance checks to ensure inmate/patients are monitored in the appropriate time frame. OMH indicated that CNYPC CBO Policy #9.24 – Cancelled/Refused/Missed Callouts was reviewed with all psychiatric and clinical staff responsible for psychiatric callouts.

**Sullivan CF**

*Visit Overview:* conducted on March 26, 2019; five cell-side interviews conducted with two private interviews accepted; one inmate and/or patient was referred to a mental health clinician; seven 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 14 inmate/patients on Exceptional Circumstances during the Justice Center's review period.

*Compliance Findings:* Facility determined to not be in compliance with the timeframes required by the SHU Exclusion Law because two inmate/patients were not reviewed every fourteen days while on Exceptional Circumstances.

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

*QMHC Findings/Recommendations and OMH/DOCCS Response:*

A review of Exceptional Circumstances documentation found that nine out of fourteen inmate/patients remained in the SHU 25 days or more before being removed from the unit and ending their Exceptional Circumstances. The Justice Center requested additional documentation that the inmate/patients received a heightened level of care, including out of cell therapeutic treatment and programming. DOCCS responded that the inmate/patients had pending misbehavior reports, not SHU confinement time, and were placed on Exceptional Circumstances due to their serious mental illness. DOCCS recognized the Justice Center's concern and acknowledged that two pilot programs have been established to prevent seriously mentally ill inmate/patients being housed in SHU/LTKL pending the hearing process.

One inmate/patient's OMH case record contained progress notes that were repetitive and contradictory. To ensure that inmate/patients are adequately assessed, it was recommended that OMH staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes. In addition, the Justice Center recommended that the Unit Chief complete quality assurance checks to ensure that all inmate/patients mental health appointments are scheduled according to policy. OMH replied that CNYPC CBO Policy #9.30 – Progress Notes was reviewed with the clinical staff assigned to the inmate/patient and the Unit Chief conducts random audits of clinical progress notes to ensure that the notes are not a copy of previous notes and are a unique reflection of each call out.

There was no documentary evidence that an inmate/patient was seen cell side after missing two clinical call outs in accordance with CNYPC CBO Policy #9.24 – Cancelled/Refused/Missed Callouts. The Justice Center requested that OMH assess how to ensure that clinical staff maintain regular contact with inmate/patients, including retraining in Policy #9.24. In response, OMH reviewed CNYPC CBO Policy #9.24 – Cancelled/Refused/Missed Callouts with all clinical staff.

At the time of the Justice Center's site visit, one inmate was considered active screen status. An update was requested as to whether the inmate had been admitted to the mental health caseload and, if so, what his current mental health service level was. OMH reported that the inmate had been placed on the mental health caseload as a MHSL 3.

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**Summary of Mental Health Service Review Findings**

The Justice Center completes a review of the quality of mental health care provided to all inmate/patients for the six months before the suicide occurred if they were on the mental health caseload at the time of their death. Two mental health service reviews were initiated during this quarter at the Auburn CF and Green Haven CF.

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

- Termination Transfer Progress Notes erroneously documented prescribed medications at two facilities.

**Auburn CF**

The Justice Center found that although the inmate/patient's treatment met the standard of care set forth by CNYPC, there were documentation discrepancies related to the inmate/patient's medication at the time of his death. It was requested that OMH complete a review of the inmate/patient's Physician's Orders, Psychiatric Progress Notes, and Termination Transfer Progress notes to ensure that discrepancies were corrected, and all clinical staff be retrained in the specific CNYPC CBP Policies. OMH acknowledged that CNYPC CBO Policy #2.8 – Termination from Active Services was reviewed with the appropriate staff after it was determined that medications had been erroneously documented.

**Green Haven CF**

The Justice Center found that the inmate/patient was supplied a state-issued razor after he had reported suicidal ideation, intent and plan involving the use of a razor less than a month prior to his death. Justification for the use of the razor was requested. OMH responded that if an inmate/patient does not require RCTP level of care, they are provided all state-issued amenities. While DOCCS and OMH can recommend a razor deprivation for patients, the final decision is made by DOCCS. In addition, OMH indicated that the documentation supported that the inmate/patient was talking about a past incident when he had suicidal ideation. OMH further reported that at the Green Haven CF the inmate/patient had a positive rapport with the treatment team, actively participated in treatment, and did not report active suicidal ideation. In response to the Justice Center's review, DOCCS noted that there was no discussion in the treatment team meeting minutes of past suicide attempts or discussion of plans to use a razor. DOCCS issued a memo directing that all new admissions to the Residential Mental Health Treatment Units be reviewed by treatment teams to ensure that all important information is reviewed, so that the treatment team can discuss "any cautionary steps."

The inmate/patient's OMH clinical record contained multiple errors in documentation, including; conflicting documentation regarding his mental health service level, a termination transfer progress note documented the wrong medications and his core history was not updated. The Justice Center requested that corrections be made to the inmate/patient's clinical record and that all staff involved be retrained in the specific CNYPC CBO Policies. OMH responded that the inmate/patients record is sealed due to death and therefore cannot be corrected, however all appropriate staff members reviewed CNYPC CBP Policies #9.7 – Chronological Record, #9.31 – Termination Transfer Progress Note and #9.14 – Core History.