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Justice Center for the Protection of People with Special Needs

SHU Exclusion Monitoring Report

2nd Quarter 2019

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

Report: Second Quarter of 2019 (April-June)
The Justice Center initiated six SHU Compliance/Quality of Mental Health Care Reviews in the second quarter of 2019; completing 639 cell-side interviews, 44 private interviews, 153 compliance reviews, and 122 reviews of the quality of mental health care provided (QMHC).

Quarterly Summary: Second 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***
Green Haven CF – 4/18/2019	30	4	3	30	20
Taconic CF – 5/10/2019	11	2	4	3	3
Clinton CF – 5/28-29/2019	123	6	17	23	19
Greene CF – 6/10-11/2019	154	12	17	29	20
Mid-State CF – 6/10-11/2019	63	6	12	22	20
Southport CF – 6/25-26/2019	258	14	28	46	40
Totals	**639**	**44**	**81**	**153**	**122**

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 for Green Haven CF and Mid-State CF. However, the census for the remaining facilities was higher than the number of cell-side interviews conducted by the Justice Center. At the time of the Justice Center's visit to Taconic CF, the Long Term Keep Lock (LTKL) census was 12; at Clinton CF, the SHU, LTKL and Annex census was 125; at Greene CF, the SHU and SHU 200 census was 157; and at Southport CF, the SHU and SHU

[1] NYS Correction Law Section 401 (a)

200 census was 263.
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.

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:

Two out of the six facilities visited were in compliance with the timeframes contained in the SHU Exclusion Law. There were two facilities that were not in compliance because they did not complete the Special Housing Unit (SHU)/Long Term Keep Lock (LTKL) Mental Health Interviews in the designated time frames. The other two facilities did not have the Suicide Prevention Screening Guidelines Form #3152 completed in the appropriate time frame following admission.

Three of the six 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 11 inmate/patients who met the definition of serious mental illness and 24 inmate/patients on Exceptional Circumstances at the three facilities visited during the second quarter of 2019.

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

- Required documentation forms were not accurately completed according to CNYPC Corrections-Based Operations Policies (Three facilities)
- Inmate/patients not seen monthly or upon transfer by their primary therapist as required by OMH policy (Two facilities)
- Clinical Case Records had conflicting documentation pertaining to the Mental Health Service Levels and Substance Abuse Histories of inmates (Two facilities)

SHU Compliance Findings at Individual Correctional Facilities:

Green Haven CF

Visit Overview: Conducted April 18, 2019; 30 cell-side interviews conducted with four private interviews accepted; 3 inmates were referred to a mental health clinician; 30 records were

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

reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were two inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and six 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 three Special Housing Unit (SHU)/Long Term Keep Lock (LTKL) Mental Health Interviews were not completed according to the designated time frames outlined for Mental Health Service Level (MHSL) 1 facilities.

QMHC: Twenty 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 two inmate/patients did not have Residential Crisis Treatment Program (RCTP) referrals to the Clinical Director/Designee completed every seven days as required by CNYPC CBO policy. The failure to make referrals to the Clinical Director at CNYPC for inmate/patients who have long stays in RCTP has been a long standing and ongoing area of concern. In response, OMH is completing an administrative review of the current form and procedure. OMH will share the findings from the review with the Justice Center upon completion.

Two 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.

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

There was no documentary evidence that an inmate/patient was seen by his primary therapist at 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. In response, OMH reviewed CNYPC CBO Policy #9.30 – Progress Notes with all clinical staff at the Great Meadow CF.

Taconic CF

Visit Overview: Conducted on May 10, 2019; 11 cell-side interviews conducted with two private interviews accepted; four inmates/patients were referred to a mental health clinician; three 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: Three records reviewed for quality of mental health care and there were no issues of concern related to the quality of mental health care provided.

Clinton CF

Visit Overview: Conducted on May 28 and May 29, 2019; 123 cell-side interviews conducted with six private interviews accepted; 17 inmates and/or patients were referred to a mental health clinician; 23 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were five inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and 15 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 four DOCCS Suicide Prevention Screening Guidelines – SHU/Keeplock (KL) Admission Forms #3152 were not completed according to the designated time frames outlined for Mental Health Service Level (MHSL) 1 facilities.

QMHC Findings: 19 records reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

One inmate/patient was housed in the RCTP and was in the process of seeking a transfer to CNYPC for acute care and treatment. An update to his current status of care was requested and the inmate/patient was transferred to the CNYPC in June 2019.

There was no documentary evidence that multiple inmate/patients were seen monthly by their primary therapists or upon transfer as required by OMH policy at the Clinton CF. 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 appropriate clinical staff reviewed CNYPC CBO Policy #9.30 – Progress Notes and they supplied the Justice Center with documentation that one inmate/patient had been evaluated in the appropriate time frame.

The Justice Center's record review found documentation errors pertaining to an inmate/patient's Chronological Record. To ensure integrity of documentation and adequate mental health treatment it was requested that appropriate clinical staff members be retrained in CNYPC CBO Policies #9.7 – Chronological Records. OMH responded that clinical staff members at the Clinton CF were retrained in CNYPC CBO Policy #9.7 – Chronological Records.

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

There was no documentary evidence that an inmate/patient was seen monthly by the primary therapist as required by OMH policy at the Green Haven CF. 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 the inmate/patient was erroneously left off the master callout list and that it was captured in a progress note that was supplied to the Justice Center. In addition, the staff at the Green Haven CF have developed a new system to formulate their daily call out sheet to DOCCS to ensure that all patients are seen as scheduled.

The Justice Center's record review found documentation errors in inmate/patient clinical case records, specifically with Termination/Transfer Progress Notes. To ensure integrity of documentation and adequate mental health treatment it was requested that appropriate clinical staff members be retrained in CNYPC CBO #9.31 – Termination/Transfer Progress Notes. OMH responded that some Termination/Transfer Progress Notes had been misfiled at the time of the Justice Center's site visit and were provided. In addition, clinical staff members at the Marcy RMHU and Downstate CF were retrained in CNYPC CBO Policy #9.31.

There was no documentary evidence that one inmate/patient received his SHU/LTKL Mental Health Interview in accordance to the designated time frames at the Attica CF. The Justice Center requested that mental health staff be retrained in CNYPC CBO Policy #6.0 – Special Housing Unit Services in MHSL 1 facilities. The appropriate OMH clinical staff members at the Attica CF were retrained in CNYPC CBO Policy #6.0.

Greene CF

Visit Overview: Conducted on June 10 and June 11, 2019; 154 cell-side interviews conducted with 12 private interviews accepted; seventeen inmate and/or patients were referred to a mental health clinician; 29 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: 20 records reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:

The Justice Center's record review revealed that an inmate/patient was not seen in accordance with CNYPC CBO Policy #1.3 – Mental Health Referrals because he was not seen by OMH until 38 days after the referral was made. It was recommended that staff be retrained in CNYPC CBO Policy #1.3 – Mental Health Referrals to ensure timely intervention. OMH responded that the inmate/patient had been seen in the appropriate timeframe and that the progress note was misfiled at the time of the Justice Center's site visit and was provided.

An OMH clinical case record contained conflicting information regarding an inmate/patient's Mental Health Service Level. Given the amount of movement within the DOCCS system, it was requested that clinical staff be retrained in CNYPC CBO Policy #9.12 – Treatment Needs/Service Level Designation Form to confirm documents are complete and accurate. Upon OMH's review it was determined that a clinician at the Greene CF had erroneously documented in the inmate/patient's clinical case record and therefore a refresher training was completed with that specific clinician.

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

There was no documentary evidence that two inmate/patients were seen monthly by their primary therapists or upon transfer as required by OMH policy while at the Washington CF. It was recommended that OMH clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes to ensure notes are completed, time frames adhered to and that the Unit Chief complete quality assurance checks to ensure proper monitoring. OMH indicated that appropriate clinical staff at the Washington CF reviewed CNYPC CBO Policy #9.30 – Progress Notes.

Mid-State CF

Visit Overview: Conducted on June 10 and June 11, 2019; 63 cell-side interviews conducted with six private interviews accepted; 12 inmate and/or patients were referred to a mental health clinician; 22 records were reviewed for compliance with the timeframes required in the SHU Exclusion Law. There were four inmate/patients who met the SHU Exclusion Law criteria for the definition of serious mental illness and three 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 Special Housing Unit (SHU)/Long Term Keep Lock (LTKL) Mental Health Interviews were not completed according to the designated time frames outlined for Mental Health Service Level (MHSL) 1 facilities. OMH staff advised one interview was not completed as DOCCS did not make OMH aware of the inmate/patient's SHU admission. OMH staff advised the other interview could not be completed due to DOCCS security matters at the unit, but attempts were made to meet with the inmate/patient sooner than required per policy. In addition, documentation about an inmate/patient placed on exceptional circumstances did not include any information to show that the inmate/patient's exceptional circumstances placement was reviewed as required or when he was removed from exceptional circumstances.

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:

It was determined that four inmate/patients were designated as MHSL 1S and two were discharged from the RCTP directly to the SHU. An update was requested regarding the current housing status of the inmate/patients and their possible diversion to a RMHTU, if they were given more than thirty days of SHU/LTKL time. Both OMH and DOCCS responded that all of the inmate/patients had either been diverted or released from SHU in the appropriate time frame following their disciplinary hearings.

A MHSL 2 inmate/patient had received several disciplinary tickets for drug use and was referred for Alcohol and Substance Abuse Treatment (ASAT) treatment. The Justice Center requested an update pertaining to his placement in ASAT. DOCCS responded to the Justice Center's findings and reported that the inmate/patient had refused ASAT from January-September 2019 and had finally accepted to attend in November 2019.

The OMH clinical case record for one inmate/patient had discrepancies pertaining to a substance abuse history. Although it was noted in a psychiatric progress note and OMH Core History that the inmate/patient denied any history of substance abuse, his diagnosis record and initial screening documented substance use disorder diagnoses. It was recommended that the

OMH unit chief review the clinical case record to confirm the appropriate diagnosis and consider retraining staff in CNYPC CBO Policy #9.27 – Psychiatric Progress Notes and the unit chief should initiate a review process to ensure accuracy in documenting the appropriate diagnosis. OMH disagreed with the Justice Center's finding that the diagnosis was inaccurate since it is a clinical decision. However, in their response they indicated that the matter was also brought to the attention of the treatment team to determine whether it is clinically appropriate to remove the substance abuse diagnosis.

The Justice Center's record review found that one inmate/patient was not seen in the required time frame following his transfer to the Mid-State CF. It was requested that clinical staff be retrained in CNYPC CBO Policy #9.30 – Progress Notes and that the unit chief complete quality assurance checks to ensure that inmate/patients are monitored in the required timeframe. OMH indicated that the policy #9.30 was reviewed with clinical staff and the unit chief will review the schedule for incoming draft inmate/patients to ensure that they are scheduled according to policy.

The Justice Center was not provided documentary evidence that inmate/patients were assessed monthly in SHU by mental health staff in accordance to CNYPC CBO Policy #9.30 – Progress Notes. It was requested that clinical staff at the Mid-State CF be retrained in CNYPC CBO Policy #9.30 – Progress Notes, specifically to ensure that SHU inmates are monitored monthly. In addition, the unit chief should complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. OMH indicated that the CNYPC CBO Policy #9.30 was reviewed with clinical staff at the Mid-State CF.

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

The Justice Center's record review found that inmate/patients were not assessed monthly in SHU by mental health staff at the Clinton CF in accordance to CNYPC CBO Policy #9.30 – Progress Notes. It was requested that clinical staff at the Clinton CF be retrained in CNYPC CBO Policy #9.30 – Progress Notes, specifically to ensure that SHU inmates are monitored monthly. In addition, the unit chief should complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. OMH indicated that the CNYPC CBO Policy #9.30 was reviewed with clinical staff at the Clinton CF.

The clinical case record review determined that two inmate/patients were not seen by psychiatric staff per policy at the Collins CF and the Elmira Reception Center. The Justice Center recommended that OMH staff be retrained in CNYPC CBO Policy #9.27 – Psychiatric Progress Notes, specifically to ensure that inmate/patients are scheduled to be seen within the required time frame. The Justice Center also recommended that the OMH unit chiefs at each of the facilities complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. OMH responded by saying that one of inmate/patient's was a MHSL 4 so would not be required to be seen monthly and that was why he was seen by the psychiatrist in November 2018 and not again until April 2019, even though he had two facility transfers during that time period. The second inmate/patient was scheduled to be seen by his psychiatrist in the appropriate timeframe, however he refused and was then transferred to another facility, therefore he was not seen until 45 days after his admission to the OMH caseload.

There was no documentation to support that two inmate/patients were seen by mental health staff per CNYPC CBO Policy #9.30 – Progress Notes at the Mohawk and Fishkill CF's. It was requested that staff be retrained in the CNYPC CBO Policy #9.30 and that the unit chief at the Mohawk CF should complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. OMH reported in their response that the appropriate staff at the Mohawk CF could not be retrained as they no longer work for CNYPC. In addition, OMH supplied a clinical progress note to the Justice Center that the other inmate/patient had actually been seen in the appropriate time frame.

Southport CF

Visit Overview: conducted on June 25 and June 26, 2019; 258 cell-side interviews conducted with 14 private interviews accepted; 28 inmate and/or patients were referred to a mental health clinician; 46 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 not be in compliance with the timeframes required by the SHU Exclusion Law because six DOCCS Suicide Prevention Screening Guidelines – SHU/Keeplock (KL) Admission Forms #3152 were not completed according to the designated time frames outlined for Mental Health Service Level (MHSL) 2 facilities.

QMHC Findings: 40 records reviewed for quality of mental health care provided with findings of concern identified below.

QMHC Findings/Recommendations and OMH/DOCCS Response:
One inmate/patient was not provided a monthly session with psychiatric staff. The Justice Center recommended that OMH staff be retrained in CNYPC CBO Policy #9.27 – Psychiatric Progress Notes, specifically to ensure that inmate/patients are scheduled to be seen within the documented time frame. In addition, it was recommended that the unit chief complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. Despite the inmate/patient being prescribed medications, OMH reported to the Justice Center that the inmate/patient was not required to be seen by the OMH psychiatrist monthly, he was only required to be seen every three months because he was in a MHSL 2 SHU.

According to the records provided, one inmate/patient was not provided a private interview or higher level of care, despite having engaged in self-injurious behavior while housed in the SHU. The Justice Center requested that an explanation be provided from DOCCS as to why a security escort was unavailable, and documentation to support that the inmate/patient was evaluated by medical staff following the discovery of the self-injurious behavior. The Justice Center also recommended that OMH ensure that inmate/patients exhibiting signs of increased risk factors are evaluated in a safe setting and that the OMH Unit chief complete quality assurance checks to ensure that all mental health call outs are completed according to policy. DOCCS responded that all security supervisors were reminded of the importance of the mandatory mental health call outs and that a memorandum on call outs was re-issued and read at line up. OMH indicated that the inmate/patient in question was offered a second private interview, nine days after his non-suicidal self-injurious behavior, which he declined and was assessed cell-side.

One inmate/patient's core history lacked significant information pertaining to his suicide history and risk. The Justice Center recommended that OMH retrain staff members in CNYPC CBO Policy #9.14 – Core History to ensure that all clinical history is accurate so that treatment goals and objectives can address specific areas of need as well as a regular review by the unit chief to ensure that documentation is complete and accurate. OMH indicated in their response that CNYPC CBO Policy #9.14 could not be reviewed with the appropriate staff as the staff member involved no longer works for CNYPC.

An OMH clinical case record indicated that there was no documentary evidence that an inmate/patient was rescheduled according to policy when he refused to attend his callout with psychiatric staff. It was requested that OMH staff be retrained in CNYPC CBO Policy #2.4 – Canceled/Refused/Missed Callouts and CNYPC CBO Policy #9.27 – Psychiatric Progress Notes. It was also recommended that the OMH Unit chief complete quality assurance checks to ensure that inmate/patients are monitored in the required time frame. OMH responded that CNYPC CBO Policy #2.4 was reviewed with the appropriate clinical staff; however, since the Southport CF does not have an on-site psychiatrist, all psychiatric callouts must occur via Video-Teleconferencing and therefore cannot be conducted cell side.

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 multiple correctional facilities other than Southport CF:

Three inmate/patients were not provided monthly sessions with their primary therapist prior to their transfer to the Southport CF. It was requested that staff be retrained in the CNYPC CBO Policy #9.30 – Progress Notes and that the unit chief complete quality assurance checks to ensure that inmate/patients are monitored in the appropriate timeframe. OMH responded that it was determined that all of the inmate/patient's callouts had been cancelled by clinical staff and not rescheduled according to policy. In response, OMH indicated that CNYPC CBO Policy #2.4 – Canceled/Refused/Missed Callouts was reviewed with the appropriate staff at the Marcy and Green Haven CF.

According to the Justice Center's clinical case record review, there was no documentation to support than an inmate/patient was evaluated by clinical staff while in the RCTP at the Mid-State CF or his reason to be returned to his assigned CF. It was requested that all documentation pertaining to the inmate/patient be forwarded to the Justice Center. OMH forwarded all progress notes and clinical information as evidence that the inmate/patient was seen and evaluated appropriately.

The Justice Center's clinical case record found that one inmate/patient's Comprehensive Suicide Risk Assessment (CSRA), Diagnosis Record, Core History, and Treatment Plan were not completed according to OMH policy at Groveland CF. It was requested that due to the amount of movement in the DOCCS system OMH staff should be retrained in CNYPC CBO Policy #9.14 – Core History, CNYPC CBO Policy #9.16 – Comprehensive Suicide Risk Assessment, CNYPC CBO Policy #9.10 – Diagnosis Record, and CNYPC CBO Policy #9.22 – Treatment Plans. It was also requested that the OMH Unit Chief should review all incoming inmate/clinical case records to make sure all documentation is completed and filed according to CBO policies and procedures. OMH acknowledged that CNYPC CBO Policies #9.14, #9.16, #9.10, and #9.22 were all reviewed with the Groveland CF clinical staff. In addition, OMH forwarded the completed documentation.

Two inmate/patients CSRA's appeared to be contradictory to the collateral information in their core histories, such as engaging in self-injurious behaviors. The Justice Center recommended that staff be retrained in CNYPC CBO Policy #9.16 – Comprehensive Suicide Risk Assessment as accurate, complete and uniform historical documentation is essential to main quality mental health treatment for inmate/patients. In addition, the unit chief should complete quality assurance checks to ensure that documentation is accurate and completed according to policy. It was later determined by OMH that there could have been two different self-reports to two separate clinicians by the first inmate/patient, so a new CSRA was completed to capture the inmate/patient's reported history of self-injurious behavior. Regarding the second inmate/patient, CNYPC CBO Policy #9.16 was reviewed with the clinician at the Sullivan CF to ensure accurate information pertaining to suicide risk is identified.

The Justice Center's record review determined that one inmate/patient's OMH clinical case record contained conflicting documentation regarding a MHSL at Upstate CF. In order to ensure the integrity of the documentation given the amount of movement within the DOCCS system, it was requested that staff be retrained in CNYPC CBO Policy #9.12 – Treatment Needs/Service Level Designation Form and CNYPC CBO Policy #9.7 – Chronological Record Form. Following OMH's review it was determined that a Treatment Needs/Service Level Designation Form had been completed but was not filed at the time of the Justice Center's site visit. The new form was forwarded to the Justice Center and the appropriate clinician at the Upstate CF was retrained in CNYPC CBO Policy #9.12.

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Summary of Mental Health Service Review of Suicides 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 Elmira CF and Bedford Hills CF.

Elmira CF

Background

The inmate/patient entered the DOCCS Reception Center in March 2019 and admitted to the mental health caseload due to paranoia and a documented suicide watch while in the county jail. Once released from suicide watch, he was placed in an area of high observation for the remainder of his stay in county jail. Within days of his transfer to the DOCCS Reception Center, the inmate/patient was placed in the Residential Crisis Treatment Program (RCTP) for threats of self-harm, displaying high anxiety/stress and was requesting psychotropic medications. He remained in the RCTP and following his release, was readmitted to the RCTP two days later voicing thoughts/threats of self-harm. He remained in the RCTP for two more days, requesting to go back after presenting as future oriented, denying suicidal ideation, intent or plan. The inmate/patient completed suicide shortly after his release from the RCTP.

Justice Center Findings/Recommendations and OMH/DOCCS Response:

The Justice Center found deficiencies in the inmate/patient's care that included multiple errors in documentation, a lack of medical referrals and minimal evidence of offering diverse mental health treatment options to engage the inmate/patient in care. It was requested that OMH retrain OMH staff in CBO CNYPC Policies #9.16 – Comprehensive Suicide Risk Assessment, #9.30 – Progress Notes, and #9.27 – Psychiatric Progress Notes to ensure that clinical staff complete all required forms and documentation. In addition, the Justice Center requested that the OMH unit chief complete quality assurance checks to ensure that all documentation is accurate and completed according to policy. OMH acknowledged that per their own review of the incident, the unit chief and the clinical director conducted clinical supervision with the responsible OMH staff members to assess their understanding of the policies and discussed the importance of ensuring documentation is complete and accurate.

An RCTP Nursing Assessment documented that the inmate/patient had a mark on his neck but there was no additional information documenting this discovery, such as a referral to medical or elsewhere to address the medical concern. The Justice Center requested information demonstrating that referrals were made to DOCCS medical and if no referrals were made, the Justice Center requested an explanation about why a referral or evaluation was not completed. OMH deferred to DOCCS related to any medical referrals in the RCTP noting that OMH and DOCCS medical staff meet regularly to review inmate/patients and formal referrals are not needed because it is completed as a matter of routine. DOCCS reported that there was no documentation to support that any referrals to medical had been completed.

The inmate/patient's clinical case record indicated that multiple OMH staff referenced the inmate/patient's withdrawal symptoms and substance abuse related issues with no record of the inmate/patient being assessed or referred to medical staff or the infirmary. OMH reported in their response that the OMH prescriber was addressing the inmate/patient's symptomology while assessing for inmate/patient's possible drug use versus any signs of psychosis. Therefore, there was no need for OMH staff to consult with DOCCS medical at that time.

Lastly there was no documentary evidence that OMH attempted diverse psychotherapeutic approaches after the inmate/patient presented with psychiatric deterioration and decompensation. The Justice Center requested that the Clinical Director complete a comprehensive review of the mental health care provided to the inmate/patient to include the different therapeutic approaches that could have been utilized in the days leading up to the suicide.

OMH disagreed with the Justice Center's finding. OMH indicated that this was the first time the inmate/patient had received services and it was imperative for the treatment team to first maintain the inmate/patient's safety and attempt a return to baseline functioning before exploring alternative treatments modalities.

Bedford Hills CF

Background

The inmate/patient had an extensive history of receiving outpatient mental health services prior to her incarceration and entered the DOCCS Reception Center in April 2019. Although she reported a history of suicide attempts, she denied current suicidal ideation, and declined a

referral to OMH staff acknowledging she had recently met with mental health staff and that should she experience thoughts of self-harm, she would notify security or guidance staff.

Later in her first month of incarceration, the inmate/patient reported experiencing suicidal ideation, and that she had attempted suicide the previous week by allegedly ingesting multiple dosages of her daily medication and supplements. She denied a current plan for suicide. Although resistant, she was admitted to the Residential Crisis Treatment Program (RCTP) and was placed on a one on one watch due to feeling stressed, depressed, and having suicidal ideation but no plan. Over the course of her RCTP admission she denied symptoms of suicidal ideation and psychosis, was removed from one on one supervision, remaining in observation for continued monitoring and stabilization. She was ultimately discharged back to Reception as a general population inmate after stating that she wanted to work on her appeal, and denied both suicidal and homicidal ideations. Two days later, the inmate/patient completed suicide. The manner of suicide did not involve medication ingestion.

Justice Center Findings/Recommendations and OMH/DOCCS Response:

The Justice Center found that the inmate/patient was left unsupervised for over two hours prior to her death and requested the staffing levels for her housing level and the policy for completing inmate status checks. DOCCS responded that the inmate/patient was considered a general population inmate therefore was able to walk freely through her housing unit. At the time of the incident, there was one-unit officer and a rover officer that had other duties on more than one unit.

Per documentation received, when the inmate/patient reported to OMH staff that she had ingested multiple medications the previous week, she was transferred to the Residential Crisis Treatment Program. The Justice Center requested any guidance or assessment tools that DOCCS uses regarding inmate possessions of medications and any investigations that may have been completed pertaining to the alleged incident. DOCCS indicated the Offender Rehabilitation Counselor (ORC) completed a mental health referral that same day and the inmate was seen by the DOCCS medical nurse and after an interview and review of the record was determined to be able to continue with her current medication regimen.

The record review found that the inmate/patient continued to self-report and exhibit symptoms of depression and anxiety OMH responded that if an inmate/patient does not require Residential Crisis Treatment Program level of care, they will be released once it is determined that they are no longer in a state of crisis, such as the inmate/patient in question. As it was determined that the inmate/patient's overall risk for imminent harm had been mitigated, there was no further information for OMH to share with DOCCS. Lastly, OMH also reported that they disagreed with the Justice Center's findings that there were deficiencies related to the standard of care provided by CNYPC.