



Commission on Quality of Care &
Advocacy for Persons with Disabilities

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A Review of:

Mental Health Screening

Access to Mental Health Services, and the

**Mental Health Status of People in
Segregated Confinement**

in New York State Correctional Facilities

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Review of Mental Health Screening, Access to Mental Health Services, and Mental Health Status of People in Segregated Confinement in New York State Correctional Facilities

Executive Summary

The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) is authorized by the 2008 Special Housing Unit (SHU) Exclusion Law to monitor the quality of mental health care provided to people who are incarcerated in correctional facilities operated by DOCCS. The SHU Exclusion Law recognizes the need to provide people who are incarcerated -- and who have been diagnosed with a serious mental illness -- with access to mental health treatment during their incarceration.

There are approximately 57,000 people incarcerated in correctional facilities operated by the New York State Department of Corrections and Community Supervision (DOCCS) and about 15 percent, or 8,300, receive mental health care provided by clinical staff employed by the New York State Office of Mental Health (OMH). Approximately 4 percent of incarcerated people are diagnosed with a serious mental illness.

In December 2007, OMH and DOCCS instituted a mental health screening process for all people who are incarcerated upon their entry into DOCCS facilities. After the screening, each person is assigned a level of mental health need, and that level determines the mental health services the person receives and is one of the criteria used to determine the correctional facility in which the person will be housed.

This is a review of the mental health screening process for people entering DOCCS custody from county jails, and their subsequent access to mental health services in state correctional facilities, as well as the mental health status of those who received segregated confinement sanctions within their first six months of incarceration.¹

This review is based on data obtained during the initial mental health screening for 470 people who entered DOCCS custody during one week in October, 2010.² CQC also received data on mental health service utilization and disciplinary sanctions resulting in segregated-confinement during the first six months of incarceration for these 470 individuals. Mental health and correctional records were reviewed for a six month period for 60 of these people, and 14 of these people were interviewed by CQC staff. CQC also interviewed 87 DOCCS and OMH staff assigned to reception centers and intake facilities and received 312 surveys completed by staff, people who were incarcerated, and their family members. DOCCS and OMH staff at the agencies' central offices and at the individual facilities CQC visited provided a high level of cooperation throughout the review process.

The overall findings of this review are:

- DOCCS and OMH have designed and implemented a screening process that ensures that people receive an assessment of mental health needs upon entry into DOCCS custody.

¹ CQC completed a review in May 2010 of the residential crisis treatment programs (RCTP) for inmates in need of immediate mental health evaluation and/or observation and treatment.

² October 18-22, 2010.

- People who are determined to need mental health services by OMH staff receive those services in compliance with OMH procedures and many people appeared to benefit from mental health services.
- OMH clinicians had a very limited amount of collateral information, particularly from family members, about their patients.
- Substance abuse needs were not addressed as part of mental health treatment.
- Psychiatric medication was changed frequently, sometimes without any apparent clinical reason.
- Most of the people who were discharged from the mental health caseload were refusing medication and said they did not want mental health services.
- Forty-seven percent of the people who received disciplinary segregation sanctions³ during the six months reviewed reported they had received mental health services in the past and 18 percent were on the mental health caseload at the end of the six month review period.

Based on these findings, CQC recommends that OMH:

1. obtain more collateral information about people on the mental health caseload, especially from family members, to improve treatment planning and outcomes;
2. address substance abuse needs as part of mental health treatment and work with DOCCS to expand substance abuse treatment programs for people with co-occurring mental health and substance abuse disorders;
3. develop and implement a medication review protocol, and track medication changes by facility on a quarterly basis in order to provide oversight to clinical staff;
4. review decisions to terminate people from the mental health caseload to ensure that those people who are discharged from the caseload are not in need of continued mental health services and all appropriate engagement strategies have been exhausted; and
5. maintain the mental health staffing in all SHU and long-term Keeplock galleries to provide timely access to mental health treatment for people in segregated confinement.

³ SHU and Keeplock.

Table of Contents

Background	p. 1
Purpose and Scope of Review	p. 2
Mental Health Screening Process Findings	p. 3
Screening Process	p. 3
Disposition of People Screened	p.4
Mental Health Utilization Findings: First Six Months	p. 5
Mental Health Level and Diagnosis	p. 5
Access to Mental Health Services and Programs	p. 7
Treatment Plans and Collateral Information	p. 9
Substance Abuse Treatment	p. 10
Medication	p. 11
Discharges from Mental Health Services	p. 12
Disciplinary Confinement Findings: First Six Months of Incarceration	p. 13
Conclusion	p. 14
Recommendations	p. 15
Appendix A – Structured Interview Form	p. 16
Appendix B – Screening Process: Survey and Interview Responses	p.18
Appendix C – Caseload and Demographic Data	p. 20

BACKGROUND

Chapter 1 of the Laws of 2008, the Special Housing Unit (SHU) Exclusion Law, gave the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) responsibility to monitor the quality of mental health care provided to people who are incarcerated in correctional facilities operated by the New York State Department of Corrections and Community Supervision (DOCCS). The SHU Exclusion Law recognizes the need to provide people who are incarcerated -- and who have been diagnosed with a serious mental illness -- with access to mental health treatment during their incarceration.

There are approximately 57,000 people incarcerated in state-operated correctional facilities and about 15 percent, or 8,300, receive mental health care provided by clinical staff employed by the New York State Office of Mental Health (OMH). Approximately four percent of incarcerated people are diagnosed with a serious mental illness.

In December 2007, OMH and DOCCS instituted a mental health screening process for all people who are entering a DOCCS facility. Upon entry, all individuals who are incarcerated are to be screened for mental health needs within 48 hours by clinical staff employed by OMH. After being screened, each person is assigned a level of mental health need; that level determines the mental health services a person receives and is one of the criteria used to determine the correctional facility in which the person will be housed. People who are determined to have a serious mental illness (SMI) may only be housed in facilities that provide a full array of mental health services.

In addition, at any time during their incarceration an individual who is incarcerated may be referred to mental health services by DOCCS staff, the individual, another individual who is incarcerated or a family member; and, if mental health staff determines that mental health services are needed, the person will be admitted to the mental health caseload.

When universal mental health screening began in 2007, OMH created a structured interview form for OMH clinical staff⁴ to use and complete. The structured interview is based on the National Commission on Correctional Health Care guidelines for intake screenings.⁵ The interview form is designed so that if a person answers yes to certain questions, individually or in combination with other questions, the clinician is required to refer that person to either further mental health screening or admission to the mental health caseload. As part of the screening process, OMH also conducts a suicide prevention screening interview.⁶

This initial, brief interview includes 21 questions concerning psychiatric history, current mental health status, emotional response to incarceration, and intellectual functioning, such as:

- Have you ever been in a hospital for emotional or mental health problems?
- Have you ever received outpatient treatment for emotional or mental health problems?

⁴ Licensed social workers (16 FTEs), master and doctoral level psychologists (16 FTEs), and rehabilitation counselors (6 FTEs). Rehabilitation counselors include bachelors and masters level staff. The masters degree is typically in counseling psychology.

⁵ See Appendix A for a copy of the form.

⁶ The score generated from the suicide prevention screening is documented on the mental health structured interview form. The screening interview form also requires the clinician to complete information about language barriers, and the results of the suicide screening administered by OMH staff.

- Are you currently taking any medications prescribed for you by a physician for an emotional or mental health problem?
- Have you received SSI/SSDI for mental illness in the past?
- Are you currently experiencing suicidal thoughts?

During the week of October 18, 2010, 470 individuals who entered the correctional system were screened. In total, 189 or 40 percent of the people screened answered yes to one or more of these questions and 25 percent answered yes to two or more of the questions above; a finding that supports the need for appropriate access to mental health services in correctional facilities.⁷

PURPOSE AND SCOPE OF REVIEW

The purpose of this review was to:

1. determine if mental health screenings by OMH for individuals who enter DOCCS reception are in compliance with OMH policies;⁸
2. examine the utilization of the mental health status for individuals during the first six months of incarceration; and
3. review the mental health status for individuals who were disciplined during their first six months of incarceration and whether they received mental health services in compliance with the SHU Exclusion law.

CQC's review included:

- a review of the policies and procedures for mental health screening and referral including the qualifications, training and supervision/oversight of staff conducting mental health screening;
- site visits to seven correctional facilities⁹;
- interviews with OMH and DOCCS staff conducting assessments at the reception centers;
- a survey of people who were incarcerated, staff, and family members¹⁰ regarding the mental health screening process and access to mental health services while incarcerated;
- a review of demographic, housing, disciplinary sanctions and mental health related data (i.e., mental health level, diagnosis) for individuals at the time of entry into a correctional facility and after their first six months of incarceration; and
- a review of OMH and DOCCS records for 60 people who entered a correctional facility during the week of October 18, 2010. The record review was for the six-month period following entry into the facility.¹¹ CQC's review included people who were determined not to need mental health services at time of entry, as well as those who either were directly admitted to the mental

⁷ See appendix C for additional information about responses to these questions.

⁸ Source: CNYPC Corrections-Based Operations Manual.

⁹ Albion, Bedford, Clinton, Downstate, Elmira, Ulster, and Wende Correctional Facilities.

¹⁰ Family member responses came from an on-line survey conducted by CQC that was open to anyone, not just family members of people who were screened the week of October 18, 2010.

¹¹ CQC reviewed files of 18 women and 42 men.

health caseload after assessment or who received a full mental health evaluation after assessment. CQC interviewed 14 individuals whose records were reviewed.

CQC FINDINGS

A. Mental Health Screening Process Findings

1. Screening Process

Mental health screening interviews are conducted in private offices by OMH staff. OMH staff interviewed by CQC said the initial screening takes between fifteen and twenty minutes to complete. A common theme expressed by some DOCCS and OMH staff and people who were incarcerated was that the screening process felt “rushed.” In addition, some individuals reported that they did not feel they could be completely honest during the mental health screening interview because, as one said, “In prison, nothing is confidential.”¹²

Before conducting the mental health screening interview, OMH staff review all records that are sent by the county jail. These records include health and mental health-related information, including medication utilization while in the county jail. Mental health staff also review the Pre-Sentence Report (PSR) prepared by the county probation department which is completed for everyone prior to their sentencing.¹³ Prior diagnosis and episodes of mental health care are reviewed for everyone who was previously incarcerated.¹⁴

Over 70 percent of the OMH staff interviewed by CQC said that the information they received from county jails was incomplete or inconsistent. The biggest problems concerned medication. OMH staff reported that whenever there is incomplete or inconsistent information regarding medication, the sending facility is contacted for clarification.¹⁵ CQC’s record review also found that many forms submitted by county jails were incomplete and/or contained information that was not consistent with the rest of the information submitted (e.g., one form indicated the person was on psychiatric medication and another form noted that there were no medications).

According to the screening process, individuals must be screened by mental health staff within 48 hours of entry into DOCCS custody. During the week of October 18, 2010, CQC found that 90 percent (420) of the 470 people entering the correctional system received an assessment of their mental health needs within the 48 hours of arrival in compliance with OMH policy. More than half of those screened received a mental health screening on the same day they entered DOCCS

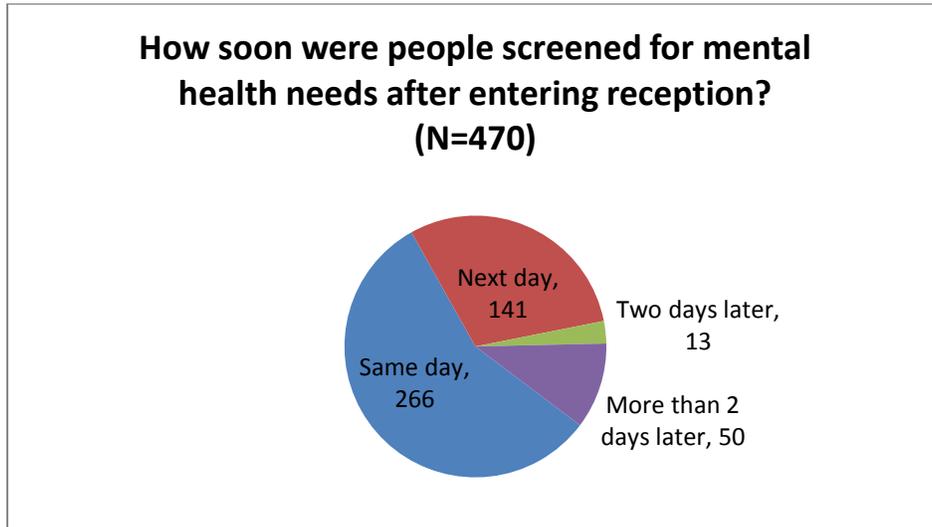
¹² See Appendix B for survey and interview responses.

¹³ The PSR is used by the court to determine an appropriate sentence and includes legal and extralegal information about the person including education, employment and mental health and substance abuse history. The PSR is not available for people returned to DOCCS custody due to a parole violation. There were 194 people returned to DOCCS on a parole violation during the week of October 21. One hundred twelve were inmates who were on their first bid and eighty-two had been incarcerated previously.

¹⁴ Previous mental health level and language proficiency during prior incarcerations is also available for review by mental health staff prior to conducting the mental health evaluation. During the CQC review week, 61 percent of the inmates had a previous incarceration and 8 percent were on the mental health caseload previously.

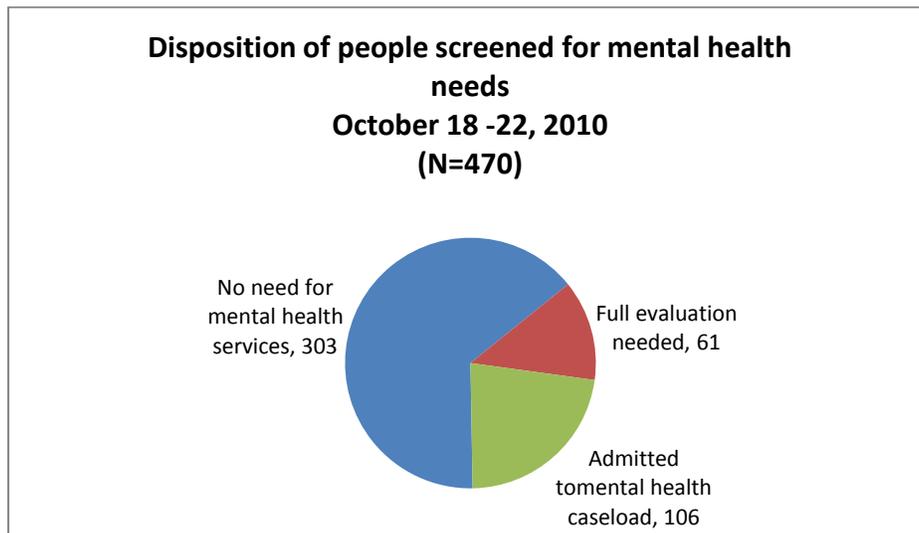
¹⁵ Staff noted that the completeness of records from inmates who were transferred from Rikers Island had been improving in recent years. Eleven percent of the inmates during CQC’s review week came from Rikers Island.

custody. The majority (48) of the 50 people who were screened more than 48 hours after arrival entered DOCCS custody on a Friday.¹⁶



2. Disposition of People Screened

Approximately two-thirds of the individuals (303 people) who entered the correctional system during the CQC’s sample week in October 2010 were determined by OMH not to have a need for mental health services. For the remaining one-third of the individuals, 161 were admitted to the mental health caseload; and another 61 were referred for a full evaluation in accordance with OMH procedures.



¹⁶ One person arrived on Thursday and was screened on Monday, and was not admitted to the mental health caseload and received no segregated disciplinary sanctions during the first six months of incarceration. The second person arrived on a Thursday and was screened on a Monday, was admitted to the mental health caseload and released from prison in April. CQC did not review the files of these two people so the reason for the delayed mental health screening is unknown.

CQC found that two individuals, who were determined not to need mental health services, should have either been admitted to the mental health caseload or referred for a full evaluation. Although these two individuals answered yes to having had a prior hospitalization (one of the criteria which should have made them eligible for a further evaluation), OMH determined that they did not need mental health services and did not refer them for a full evaluation. CQC reviewed the case file for one of the individuals and the mental health screening form noted that the individual was hospitalized as a child. Over the next six months, there were no subsequent mental health referrals and the person received only one disciplinary infraction that resulted in a loss of privileges.

For the 61 people who received a full evaluation, only three were determined to need mental health services after the full evaluation. Of these 58 people, 27 reported they were hospitalized for an emotional or behavioral health problem in the past, 33 reported receiving outpatient mental health services in the past, and nine were taking medication at the time of the initial mental health screening. Almost half of the people who received SSI/SSDI in the past were not admitted to mental health caseload.¹⁷

Mental Health History and Screening Disposition				
Answered Yes on Mental Health Screen	Admitted to Services	Full Evaluation and Admitted to Services	Full Evaluation NOT admitted to services	No Mental health Need
Inpatient	63	0	27	2
Outpatient	86	0	33	43
Medication	85	1	9	0
SSI/SSDI	21	0	6	4
More than One of the Above	89	0	26	3

B. Mental Health Utilization Findings: First Six Months

While the screening process ensures timely mental health screening upon entry into DOCCS custody, follow-up by mental health staff is essential to ensure that people who are in need of mental health services receive the services and medication they need while they are incarcerated. This is especially important for those who may not have felt comfortable discussing their mental health needs during the initial interview with mental health staff.

The following are results of CQC’s review of mental health utilization data during the first six months of incarceration.

1. Mental Health Level and Diagnosis

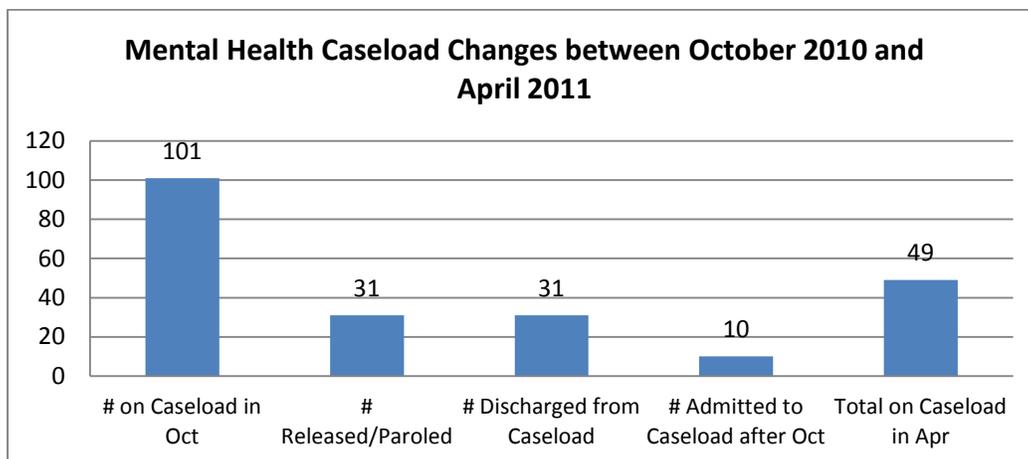
After assessment, each person is assigned a mental health level between one and six.¹⁸ A person’s mental health level determines the level of mental health service received and is one of the criteria used to determine the correctional facility in which the person will be placed.

¹⁷ The four people who did not receive a full evaluation answered no to questions about inpatient and outpatient services and were not on medication when they entered DOCCS reception.

¹⁸ There is no mental health level 5.

Level	Level of Mental Health Need	DOCCS Facility Classification Level
1	Major/serious mental illness, active symptoms, six months of instability	Full-time mental health staff, treatment of major mental health disorders and specialized services including RCTPs ¹⁹
2	Major/serious mental illness, no significant active symptoms, treatment and medication-compliant for one year, six months stability	Full-time mental health staff, treatment of inmates with less acute mental health disorders
3	Short-term medication needs or can function in setting with part-time mental health staff.	Part-time mental health staff, treatment and medication for moderated mental health disorders
4	Mild disorders, no medication needs	Part-time mental health staff, treatment for limited interventions, no medication monitoring
6	Does not require mental health services	No onsite mental health staff

For the 470 people in our review, OMH provided CQC with the mental health level and diagnosis for each individual at two different points in time: October 29, 2010 and April 30, 2011. CQC found that more people were discharged from the mental health caseload than admitted over the six-month period. On October 29, 2010, 101 people were on the OMH caseload.²⁰ By April 30, 2011, only 49 people remained on the mental health caseload²¹ - - 31 were released, 31 were discharged from the caseload and 10 were admitted to the mental health caseload.²²



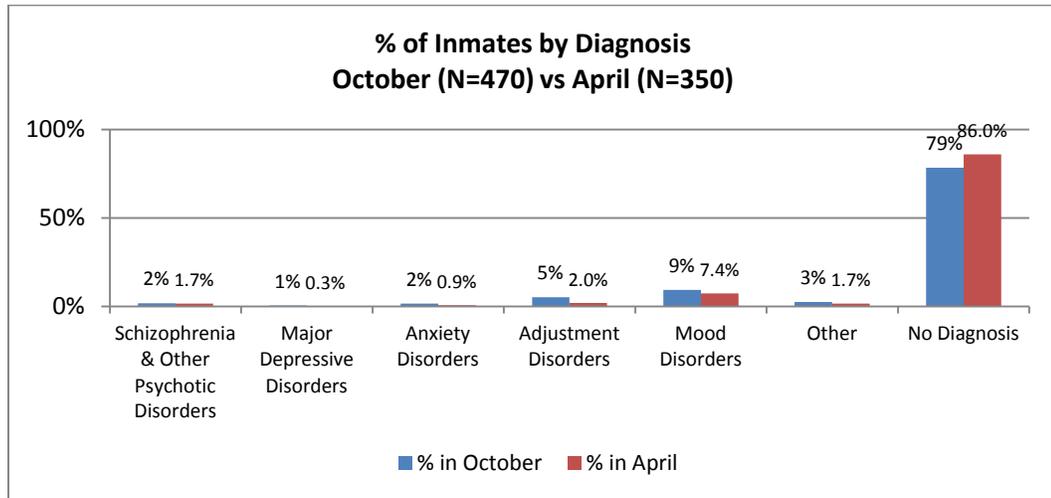
¹⁹ Residential Crisis Treatment Programs.

²⁰ Ten of the 106 people initially determined to need mental health services were not on the caseload on October 29; three people who received a full evaluation were on the caseload and two people who were determined not to need mental health services after the initial screening were on the caseload. See Appendix C for the percentage of people by mental health service level in October and April.

²¹ One hundred twenty people who were screened by mental health staff at reception during the week of October 18, 2010 were no longer incarcerated on April 30, 2011. One person died, and the remainder were released or paroled.

²² Thirty-five people who were admitted to mental health caseload at reception were released or paroled before April 30, 2011, including five people who were discharged from the mental health caseload before October 29, 2010.

As noted in the chart below, the percent of people who either had no psychiatric diagnosis or were determined not to need mental health services increased from 79 percent in October 2010, to 86 percent in April 2011. CQC also found that during the first six months of incarceration, 34 percent of the people who had a psychiatric diagnosis in October had their diagnosis changed.²³



2. Access to Mental Health Services and Programs

CQC found that many people appeared to benefit from mental health services during the first six months of incarceration. CQC’s review found that people who were on the mental health caseload were seen by mental health staff at least monthly; and those that were on medication had their medication monitored by a psychiatrist or nurse practitioner. People who engaged in treatment, appeared to benefit from mental health treatment, and most of those engaged in treatment did not receive disciplinary sanctions.

People who were incarcerated and their family members also told CQC that the quality of mental health care varied by facility. Forty-two percent of the people who were incarcerated and 16 percent of family members who responded to the CQC’s survey said they thought mental health staff were helpful.²⁴ Everyone who was interviewed said they spoke with mental health staff in a private room, knew why they were receiving mental health services, and most knew the names of the clinicians who treated them. Further, the documentation reviewed showed that people who requested to see a mental health staff person, including those who were not on the mental health caseload saw mental health staff in accordance with OMH policies, and there did not appear to be lengthy delays before a person saw someone from OMH.²⁵

²³ Those individuals diagnosed with a serious mental illness were all assigned either a mental health level of 1S or 2S in October and April in compliance with OMH procedures. There was one individual who had the “S” designation removed and this was done in compliance with OMH procedures.

²⁴ Five people who were incarcerated and interviewed thought mental health staff were helpful.

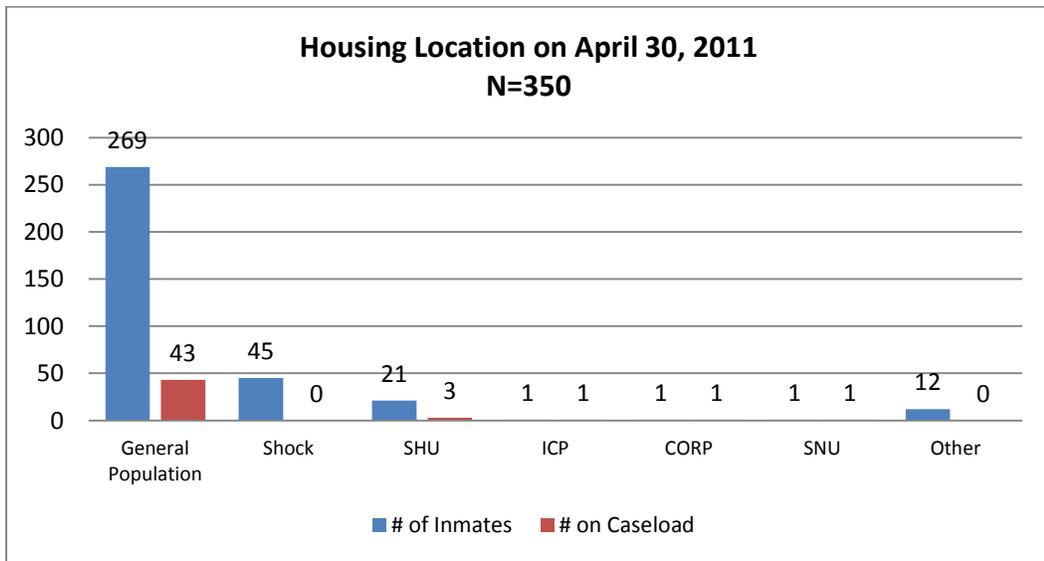
²⁵ CNYPC procedures state that “referrals will be triaged upon receipt and responded to in a time frame consistent with the referral”.

a. Residential Mental Health Treatment Units

Most of the approximately 8,000 people on the mental health caseload are housed in general population. People who reside in general population participate in programming provided by DOCCS and receive mental health services from OMH staff. Typically, they are seen by mental health staff at least once a month and if they are on medication, their medication is monitored by a psychiatrist or nurse practitioner.

DOCCS and OMH also operate residential mental health treatment units (RMHTUs)²⁶ for individuals who are unable to function in the general population because of impairments related to their mental illness. The RMHTUS have the capacity to house approximately 1,400 people.

Most of the people in CQC’s review were housed in general population. Of the 470 people reviewed, only three people on the mental health caseload were transferred to a residential treatment unit (ICP, CORP, SNU).²⁷ All three individuals were transferred to the residential treatment unit from the Residential Crisis Treatment Program (RCTP) and were diagnosed with a serious mental illness.²⁸



²⁶ Residential mental health treatment unit is defined in the SHU Exclusion Law as “housing for inmates with serious mental illness that is operated jointly by the department and the office of mental health and is therapeutic in nature.”

²⁷ ICP is the Intermediate Care Program, CORP is the Community Orientation and Re-entry Program, and SNU is the Special Needs Unit Program. SNU and CORP are not defined as a residential treatment unit in the SHU Exclusion law.

²⁸ There were a total of 13 people diagnosed with a serious mental illness on October 29, 2010 and there were 7 people with a serious mental illness on April 30, 2011. Six people with a serious mental illness were released from prison before April 30, 2011. The person who was admitted to the ICP was placed in the ICP by the end of December 2010, the person transferred to CORP was transferred in February 2011, and the person transferred to the SNU was transferred in March 2011, after being discharged from CNYPC.

b. Crisis and Inpatient Care

In addition to the residential mental health treatment units, people who need immediate treatment or observation can be seen in one of the fourteen Residential Crisis Treatment Programs (RCTPs) located in correctional facilities. In addition, the Central New York Psychiatric Center (CNYPC) operates a 210 bed maximum security inpatient facility in Marcy, New York.²⁹ Nine people whose files were reviewed by CQC had been transferred to the RCTP and one person was transferred to CNYPC.³⁰ Four of these people were transferred to the RCTP directly from reception and three were transferred from SHU or Keeplock. There were two inmates with four RCTP transfers.³¹

Based on the information reviewed and given the small number of transfers within the six months reviewed for this cohort of people, OMH and DOCCS may want to review policies and procedures to determine if increased access to the CNYPC would be appropriate.

3. Treatment Plans and Collateral Information

CQC found that while treatment plans were completed within 30 days for most of the people on the mental health caseload, OMH clinicians had a very limited amount of collateral information, particularly from family members, about their patients.³²

OMH procedures state that treatment plans should “allow the patient and family an opportunity for input.”³³ All treatment plans reviewed by the Commission were signed by the person receiving services indicating that the person was in agreement with the treatment plan. However, no family input was documented in any of the treatment plans reviewed. “Family not available” was the most frequent notation in the treatment plans reviewed.

Over 50 percent of families who responded to CQC’s survey said they did not know how to contact mental health staff. Those family members who knew how to contact mental health staff said that at some facilities, mental health staff communicated regularly with them and were helpful, but at most facilities, it was difficult to contact OMH staff. Many of those that were able to speak with mental health staff commented that staff did not listen to their concerns or were “defensive” or “unfriendly;” others commented that a “revolving door” of mental health staff hindered communication.

OMH procedures also require clinicians to make every effort to obtain information about mental health services that a person received prior to incarceration. All records from inpatient

²⁹ CNYPC is the only facility where male and female inmates may be involuntarily hospitalized. New York’s inpatient and outpatient corrections-based mental health services are fully accredited by The Joint Commission (formerly known as the Joint Commission on Accreditation of Health Care Organizations).

³⁰ CQC did not receive data about RCTP transfers or CNYPC admissions for all 470 people who were screened during the review week in October, 2010.

³¹ One person was transferred to CNYPC and then placed in a SNU, the other person was on the mental health caseload residing in general population and received a Keeplock sanction. This person’s medication was changed frequently, sometimes with no documented justification, and one transfer to the RCTP was while the person was serving a Keeplock sanction.

³² 29 of the people whose files were reviewed had treatment plans completed (21 people were never on the mental health caseload and the remainder did not receive mental health services long enough to have a treatment plan completed). Treatment plans for four people were completed within 2 months. There was no notation in the record explaining the reason for the delay.

³³ CNYPC Policy #2.1

hospitalizations within the five years before incarceration are to be obtained.³⁴ According to the procedures staff are not required to request records from local community outpatient service providers or NYS Office of Alcoholism and Substance Abuse(OASAS) inpatient providers unless it is the judgment of the treating clinician that such records would add to the quality of care provided. CQC's review found that 9 of 25 people with a history of inpatient and/or outpatient mental health care had records from other providers in their case file. Only three were from outpatient service providers.

4. Substance Abuse Treatment

People with co-occurring mental health and substance abuse disorders benefit from integrated treatment that addresses both disorders. These benefits include reduced substance abuse, and improved mental health symptoms, including fewer suicidal thoughts. People with co-occurring mental health and substance abuse disorders who receive care for just their mental health needs are more likely to have poorer outcomes in treatment including low engagement levels and early termination from services.³⁵

There are a limited number of integrated substance abuse treatment options in New York's correctional facilities for people diagnosed with a mental illness.³⁶ The majority of people with co-occurring mental health and substance abuse needs live in general population and when their substance abuse treatment needs are "deferred to DOCCS" they must wait to be placed in one of DOCCS substance abuse treatment programs. Most of the DOCCS-operated substance abuse treatment programs prioritize admission based on proximity to the person's earliest release date. At many correctional facilities, a person must be within one year of their earliest release date before they are offered substance abuse treatment. DOCCS treatment programs generally do not give priority to people who have current substance abuse problems.

CQC's review of treatment plans found that people with co-occurring disorders are not being treated for substance abuse as part of their mental health treatment. The majority, 52 of the 60 people whose records were reviewed, had a documented history of current or past substance abuse, and 25 were diagnosed with a substance abuse disorder. The people with a diagnosed substance abuse disorder,³⁷ had their substance abuse treatment needs "deferred to DOCCS." or had no treatment goals concerning substance abuse. There were seven people with co-occurring disorders who received SHU and Keeplock sanctions.³⁸ One person received a SHU sanction for drug use.

³⁴ Unless the hospitalization occurred prior to a CNYPC hospitalization.

³⁵ Correctional Association of New York State. Treatment Behind Bars: Substance Abuse Treatment in New York Prisons, 2007-2010.

³⁶ Most of the residential Intermediate Care Programs operated by DOCCS and OMH provide Integrated Dual Disorders Treatment for people with co-occurring disorders (approximately 1,000 beds). Modified substance abuse programs are also offered to people diagnosed with serious mental illness in the Behavioral Health Units and Specialized Treatment Programs and in the SHU at Five Points.

³⁷ Two were admitted to mental health after being screened but were discharged before October 29 and before a treatment plan was written.

³⁸ Based on CQC file review: 5 of the 13 people who received Keeplock sanctions had a co-occurring substance abuse disorder diagnosis, and 2 of the 6 inmates with SHU sanctions had a co-occurring substance abuse disorder.

5. Medication

Staff, family members and people who were incarcerated all reported problems concerning medications. CQC also found problems with medications; mainly that psychiatric medication was changed frequently and sometimes without any apparent clinical reason. Over 25 percent of the individuals who responded to CQC's survey reported that they had problems getting medication. Nine people interviewed said their medication was changed at reception and only one person interviewed said the new medications they received were helpful.³⁹ DOCCS staff responding to the CQC's survey reported that there were often delays in getting medication and OMH staff said they often received incomplete and inconsistent medication information from county jails.

CQC reviewed the files of 60 individuals regarding medications and found that 26 individuals had their medication changed during their first six months of incarceration:

- 25 had their medication changed when they entered DOCCS custody;
- 17 had their medication changed when they transferred to another facility;
- 10 had their medication changed 5 times; and
- 6 had their medication changed 6 or more times.

Medication changes were reviewed by Stuart Grassian, M.D.,⁴⁰ who found that while some medication changes appeared to benefit people, there were other changes that did not appear to be of benefit, and, in some cases, may have been contrary to the person's diagnosis:

- Two women were diagnosed with a mild form of depression but were prescribed medications that are typically used for more serious depression or psychosis; and could potentially have serious long-term side effects.
- One person was diagnosed with a bipolar disorder and received both SHU and Keeplock sanctions. This person was prescribed antidepressants but no mood-stabilizing medications, a practice that runs the risk of destabilizing a person's mood and could lead to impulsive, disruptive behaviors, behaviors that this individual did manifest while incarcerated.
- One person had his medication changed seven times. When he complained that Seroquel was not working, instead of increasing the dose (there were no complaints about side effects), he was switched to two antipsychotics; Abilify and Zyprexa. Starting two medications at the same time makes it difficult or impossible to know whether one or both is useful or detrimental. Within a week, the patient decided the Abilify didn't work so it was discontinued and the Zyprexa dosage was increased. A few weeks later he complained of feeling too sedated on Zyprexa and asked to be put on Thorazine. After five days, he complained about side effects and was put back on Zyprexa. In this case, it appears that the prescriber made whatever changes the patient requested.

Further, when people were transferred to different facilities and had their medication and sometimes diagnosis changed, it was not clear from the documentation reviewed, whether the sending facility's psychiatrists were consulted prior to these changes.

³⁹ Two people asked to have their medication discontinued. One person requested his medications be discontinued because he wanted to get into the Shock program and one said the medications were not needed.

⁴⁰ Dr. Grassian is a member of CQC's psychiatric correctional advisory committee.

6. Discharges from Mental Health Services

According to OMH procedures, people will be “terminated” from active mental health services when the presenting problem leading to admission to services has been resolved; the person has met the discharge criteria stated in the treatment plan; or the person is released from incarceration with all necessary arrangements in place for mental health services to be continued in the community. People who refuse or deny the need for services may be terminated from active mental health services only if: the person is not designated as seriously mentally ill; and the person, as assessed by psychiatric staff, does not present as a foreseeable danger to self or others as a result of their mental health condition.

There were 31 people who were discharged from the mental health caseload between October 2010, and April 2011. Most people discharged from the caseload were initially diagnosed with an adjustment or a mood disorder, and most were a mental health level 3 on October 29, 2010.⁴¹ Many of the 31 people who were discharged from the mental health caseload said that they had received mental health services in the past during the mental health structured interview at reception:

- 22 received outpatient mental health services;
- 19 were taking medication when they entered DOCCS custody;
- 13 were hospitalized for a emotional or mental health problem;
- 5 received SSDI/SSDI for a psychiatric disability; and
- 19 had two or more of the above characteristics.

CQC reviewed the files of 10 of the 31 people discharged from the mental health caseload.⁴² None of the people whose files were reviewed were discharged from the mental health caseload because treatment plan goals were met or the initial treatment problem was resolved. Instead, eight people were discharged because they refused to take their medication and asked to be discharged;⁴³ one person was discharged with no documented reason; and one person was discharged because OMH determined that the “patient’s current level of depression does not warrant treatment.” Two people who were interviewed by CQC said that they did not want to be discharged and wanted to continue to receive mental health services. None of the documentation reviewed reflected attempts by mental health staff to engage people who were asking to be discharged from treatment.

One of the individuals who asked not to be discharged was admitted as a level 3 on October 18, 2010, and discharged on October 26, 2010, with no documented reason. A progress note dated October 25, 2010, said the person wanted to be taken off medication but wanted to continue “talk therapy.” The other person asked to see mental health staff twice during the six-month period and each time, after describing problems to mental health staff, staff determined that the person “neither requires nor desires further mental health services at this time.”

⁴¹ 15 people were initially diagnosed with an adjustment disorder and 11 people were initially diagnosed with a mood disorder, 20 were mental health level 3, 9 were level 2, 1 was level 4, and 1 was level 2S.

⁴² Two were discharged before October 29, 2010 and eight were discharged between October 29, 2010 and April 30, 2011.

⁴³ Most of the people who asked to be discharged from the mental health caseload did so because they did not like the side effects of the medication. One person refused medications because he wanted to be transferred to a Shock program and would not be accepted if he were taking psychiatric medications. This person was discharged from the mental health caseload but was never admitted to the Shock program. Shock programs are located at level 4 and 6 facilities and these facilities do not have mental health staff to monitor medications.

One person who asked to be discharged from the caseload was diagnosed with a serious mental illness on October 29, 2010, and he was discharged in accordance with OMH procedures.⁴⁴

C. Disciplinary Confinement Findings: First Six Months of Incarceration

People who are found guilty of violating a prison rule and sentenced to disciplinary segregation may be confined in SHU or Keeplock for 23 hours a day. Keeplock sentences are generally shorter than SHU sentences. In Keeplock, people are confined to their own cells or in a separate cellblock and are allowed to have more personal property than those in SHU. Under provisions of the SHU Exclusion law, people who are determined to have a serious mental illness may only be housed in facilities that provide a full array of mental health services and must be provided with access to a “heightened level of care” if they receive a disciplinary sanction of 30 days or more in SHU or Keeplock. Mental health staff complete daily rounds in SHU and in long-term Keeplock galleries.

For the six-month period reviewed by CQC, 99 people received either a SHU (27 people) or Keeplock sanction (72 people). Almost half of these individuals reported that they had received mental health services in the past and/or were on psychiatric medications when they entered DOCCS custody, and 18 were on the mental health caseload in April 2011.

Sanction	Total # Receiving Sanction	Total # With Mental Health Treatment History	Inpatient History	Outpatient History	Received SSI/SSDI	On Medication at Reception	# More Than One	On MH Caseload in April
SHU	27	12	6	10	2	4	8	7
Keeplock	72	35	13	29	8	16	19	11

No one diagnosed with a serious mental illness received a SHU sanction during the six-month review period. Two people with a serious mental illness received a Keeplock sanction during this time period.⁴⁵

Most SHU and Keeplock disciplinary sanctions (78 percent and 54 percent respectively) were for 30 days or more. Many of the people receiving sanctions of 30 days or more were on the mental health caseload: 29 percent of inmates in SHU, and 15 percent of inmates in Keeplock.

CQC reviewed the files of six people who received a SHU sanction and 13 who received a Keeplock sanction. CQC’s case review found that people on the mental health caseload received mental health visits and assessments in compliance with the SHU Exclusion Law. All six people who received SHU sanctions had received mental health services in the past, had a history of substance abuse, two had a

⁴⁴ This person was transferred to the RCTP at reception after expressing suicidal and homicidal ideation during the suicide prevention screening. Once in the RCTP, he said he exaggerated the symptoms. The serious mental illness designation was removed in November and the person remained on the mental health caseload until February. During this time, the person continued to refuse medication and mental health services. The person received one disciplinary sanction, a loss of privileges in December for refusing a direct order.

⁴⁵ Seven people received two SHU sanctions and twenty-five received two or more Keeplock sanctions. There were six people who received four or more Keeplock sanctions. One of the people receiving two SHU sanctions was on the mental health caseload and six of the people receiving multiple Keeplock sanctions were on the mental health caseload.

substance abuse diagnosis, and four were on the mental health caseload.⁴⁶ All but one of the people who received a Keeplock sanction received mental health services in the past; two were on the caseload but were discharged from mental health services after asking to be discharged:⁴⁷ Four people were transferred to the RCTP while in Keeplock or shortly after receiving the Keeplock sanction. Half of the people interviewed by the CQC thought that mental health services can either help a person avoid a disciplinary sanction or can help to reduce the disciplinary sanction.⁴⁸

CONCLUSION

DOCCS and OMH have designed and implemented a screening process that ensures that people who are incarcerated in state correctional facilities receive an assessment of mental health needs upon entry into DOCCS custody. People who are determined to need mental health services receive those services according to OMH procedures and many people appeared to benefit from mental health services.

However, a large number of people stop receiving mental health services after a few months. Many people who might benefit from treatment refuse treatment, including those receiving disciplinary sanctions. Although OMH clinicians have an opportunity and obligation to get as much collateral information about the people they are treating, this did not occur in many cases. Additional collateral information, such as input from family members, mental health records from previous inpatient and outpatient episodes of care will give the clinician more information about the person they are treating, assist in engaging the person in treatment, and improve the quality of care provided.

Treatment outcomes would also be improved by treating, and not deferring, substance abuse needs. There is a substantial body of evidence showing that effective prison-based substance abuse treatment which combines substance abuse and mental health interventions to treat disorders is the most effective means to reduce the likelihood of relapse and recidivism for participants.⁴⁹ Untreated substance abuse can also lead to disciplinary sanctions while incarcerated and undermine effective mental health treatment.

Medication can play an important role in improving mental health and promoting recovery. While it is often necessary that medication be changed, it is critically important to ensure that changes benefit the patient. Better clinical oversight of medication practices would improve care. Similarly, decisions to terminate people from mental health services should also be reviewed to ensure that people who are terminated are not in need of continued mental health services and that all appropriate engagement strategies have been attempted.

⁴⁶ Four had been hospitalized and two had also received SSI/SSDI for a mental illness. Two were on the mental health caseload in previous incarcerations but did not want to receive mental health services during this incarceration.

⁴⁷ One was discharged the month after receiving a Keeplock sanction, and the other a month before receiving a Keeplock sanction.

⁴⁸ Eight people interviewed had received a SHU or Keeplock sanction. Four people said they thought mental health helped avoid or reduce the sanction. Two people were not sure if mental health could have helped them avoid a disciplinary sanction, and three did not think that mental health could have helped them. One person did not answer the question.

⁴⁹ Peters, Wexler, and Center for Substance Abuse Treatment (U.S.), *Substance Abuse Treatment for Adults in the Criminal Justice System: Treatment Improvement Protocol (TIP) Series 44 and 42–SAMHSA/CSAT Treatment Improvement Protocols – NCBI Bookshelf*.

Finally, given the mental health service histories of people who receive SHU and Keeplock sanctions, mental health staff must maintain an active presence in SHU and long-term Keeplock galleries to ensure that there is timely access to mental health care while a person is in segregated confinement.

RECOMMENDATIONS

Based on the findings of this review, the Commission recommends that OMH:

1. obtain more collateral information about people on the mental health caseload, especially from family members, to improve treatment planning and outcomes;
2. address substance abuse needs as part of mental health treatment and work with DOCCS to expand substance abuse treatment programs for people with co-occurring mental health and substance abuse disorders;
3. develop and implement a medication review protocol, and track medication changes by facility on a quarterly basis in order to provide oversight to clinical staff;
4. review decisions to terminate people from the mental health caseload to ensure that those people who are discharged from the caseload are not in need of continued mental health services and that all appropriate engagement strategies have been exhausted; and
5. maintain the mental health staffing in all SHU and long-term Keeplock galleries to provide timely access to mental health treatment for people in segregated confinement.

Appendix A (Mental Health Structured Interview Form)

CNYPC Mental Health Screening - Structured Interview

Inmate Name: _____ DIN: _____

DOB: _____ C#: _____

Date Inmate Arrived at Reception: _____

Date Screened: _____

SECTION I: PROVIDE ADDITIONAL INFORMATION FOR ANY YES ANSWERS IN SECTION II BELOW.

Yes No

A: History

1. Have you ever been in a hospital for emotional or mental health problems?
2. Have you ever received outpatient treatment for emotional or mental health problems?
3. Have you ever exhibited suicidal behavior?
4. Do you have a history of violent behavior?
5. Have you ever been the victim of physical, emotional or sexual abuse?
6. While in school, were you ever in special education classes?
7. Have you ever had a serious injury to your head or experienced seizures?
8. Have you ever committed or been charged with a sexual offense?
9. Have you received SSI/SSDI for mental illness in the past?

<input type="checkbox"/>	<input type="checkbox"/>

B: Current Status

10. Are you currently taking any medication prescribed for you by a physician for any emotional or mental health problems?
11. Are you currently experiencing suicidal thoughts?
12. Do you currently use illegal drugs and/or alcohol?
13. Do you know today's date?
14. Do you know what prison you're in at this time?
15. Do you currently believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?
16. Do you currently feel that other people know your thoughts and can read your mind?

<input type="checkbox"/>	<input type="checkbox"/>

C: Emotional Response to Incarceration

17. Have there currently been a few weeks when you felt like you were useless or sinful?
18. Have you currently lost or gained as much as two pounds a week for several weeks without even trying?
19. Have you or your family or friends noticed that you are *currently* much more active than you usually are?
20. Do you *currently* feel like you have to talk or move more slowly than you usually do?

<input type="checkbox"/>	<input type="checkbox"/>

D: Intellectual Functioning

21. Were you ever described as a slow learner, developmentally disabled or learning disabled?

<input type="checkbox"/>	<input type="checkbox"/>
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SECTION II: Additional information

SECTION III: Comments/Impressions (check all that apply):

- Language barrier
- Under the influence of drug or alcohol
- Other (specify): _____
- Difficulty understanding questions
- Non-cooperative

SECTION IV: Suicide Prevention Screening Guidelines completed?

- Yes No Number of items endorsed _____
- Yes No Presence of significant warning signs of imminent suicide risk -- IS PATH WARM?
(If Yes, additional interview and assessment necessary)

SECTION V: DISPOSITON Note: In Section I, if inmate answered YES to any of items 1, 10 or 11, or YES to at least two of items 15-20, or if you feel it is necessary for any other reason, a full evaluation should be completed.

- Inmate not in need of mental health services – no further screening necessary
- Inmate may be in need of further mental health services – a full evaluation is necessary
- Inmate admitted to mental health services

Printed name and title of person completing screening: _____

Signature of person completing screening: _____

Appendix B: Screening Process: Survey and Interview Responses

OMH and DOCCS staff, people who were incarcerated, and family members of people who were incarcerated were asked a series of questions about the mental health screening process upon entry into DOCCS custody and about mental health services received.

Type of Respondent	# Responding to Survey	# Interviewed
People who are incarcerated	116	14
Family Members ⁵⁰	66	0
DOCCS Staff	112	52
OMH Staff	18	35
Totals	312	101

Results from surveys and interviews were:

Structured Interview:

- 80 percent of the people who were incarcerated responding to the CQC survey said they remembered meeting mental health staff when they first came to prison.
- 49 percent of family members reported that their family member spoke with mental health staff upon entry into prison.⁵¹
- 73 percent of the people who were incarcerated responding to the CQC survey said that they were able to speak privately with mental health staff during the mental health screening.⁵²
- All of the people who were interviewed said they spoke privately with mental health staff during the screening.

Mental Health History:

- 64 percent of the people who were incarcerated responding to the CQC survey said they were asked about mental health services they received before coming to prison.
- 86 percent⁵³ of the inmates interviewed reported they were asked about receipt of mental health services prior to incarceration.
- 49 percent of people who were incarcerated responding to the survey said they had received mental health services in the community.
- 64 percent of family members said their loved one received mental health services in the community before coming to prison.

Referrals to mental health:

- 94 percent of DOCCS staff responding to the survey knew how to make a referral to mental health and 65 percent said they had received training on how to make a referral.⁵⁴

⁵⁰ Family members responding were not necessarily those of the people who were screened during the week of October 18, 2010.

⁵¹ The percent of family members who said their family member spoke with someone from mental health was higher (56 percent) for those whose family member was incarcerated after 2007 than before the advent of universal screening (36 percent).

⁵² All fourteen of the inmates who were interviewed said they spoke privately with mental health staff during the assessment.

⁵³ One said “probably” and another said they were only asked about hospitalizations.

⁵⁴ 88 percent thought the training was helpful.

- All of the OMH staff who responded to CQC's survey and all but one of the 38 OMH staff interviewed thought DOCCS staff made referrals to mental health when appropriate.
- 47 percent of family members said they knew how to contact mental health staff.
- 86 percent of people interviewed who were incarcerated said they knew how to contact mental health staff.

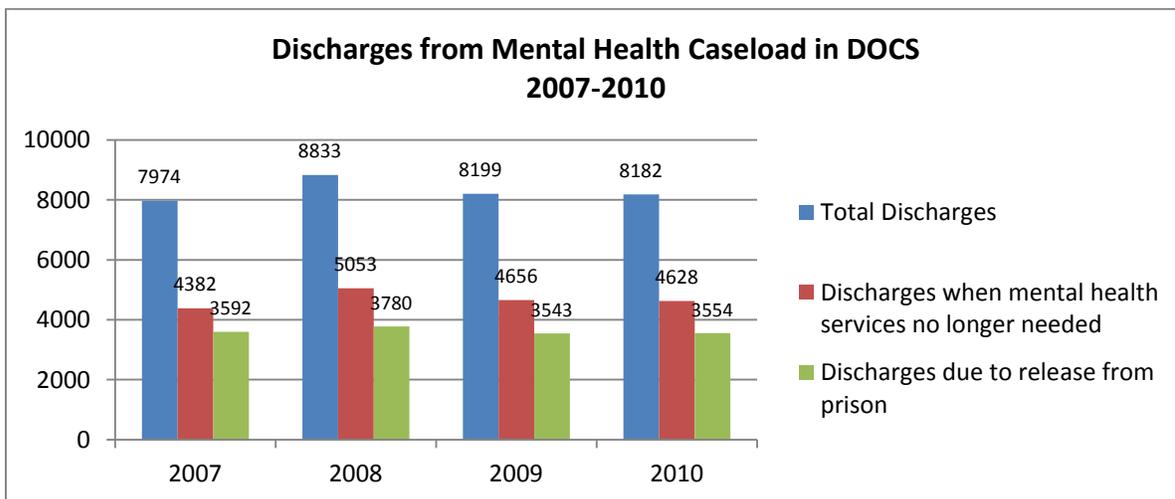
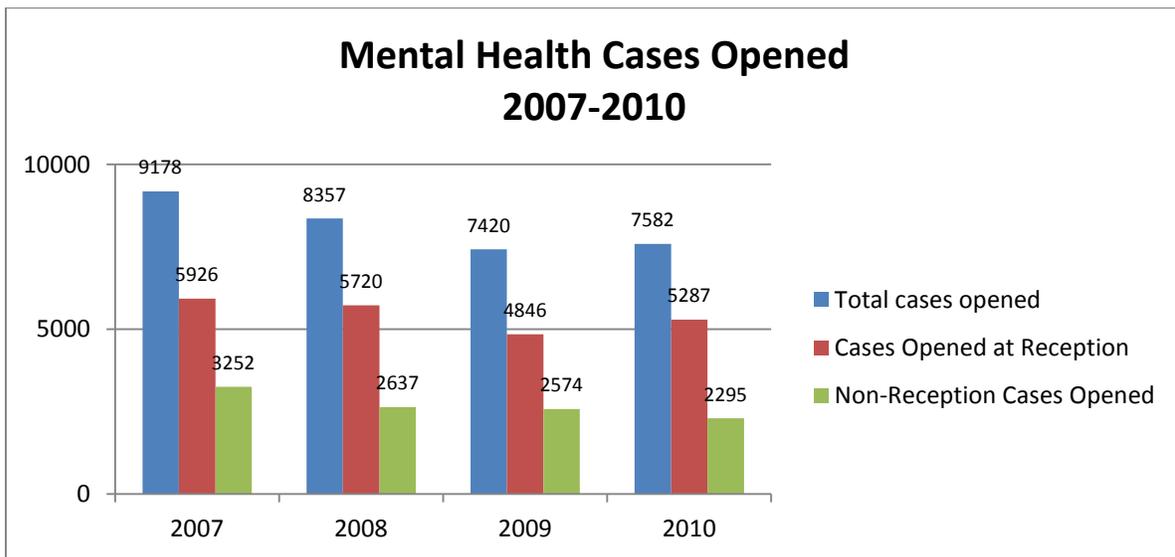
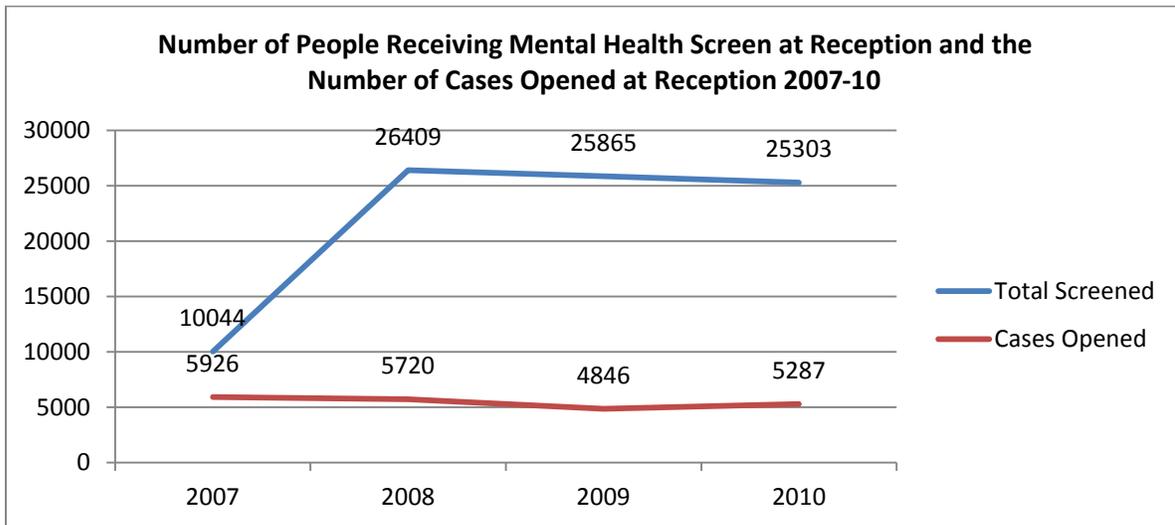
Medication

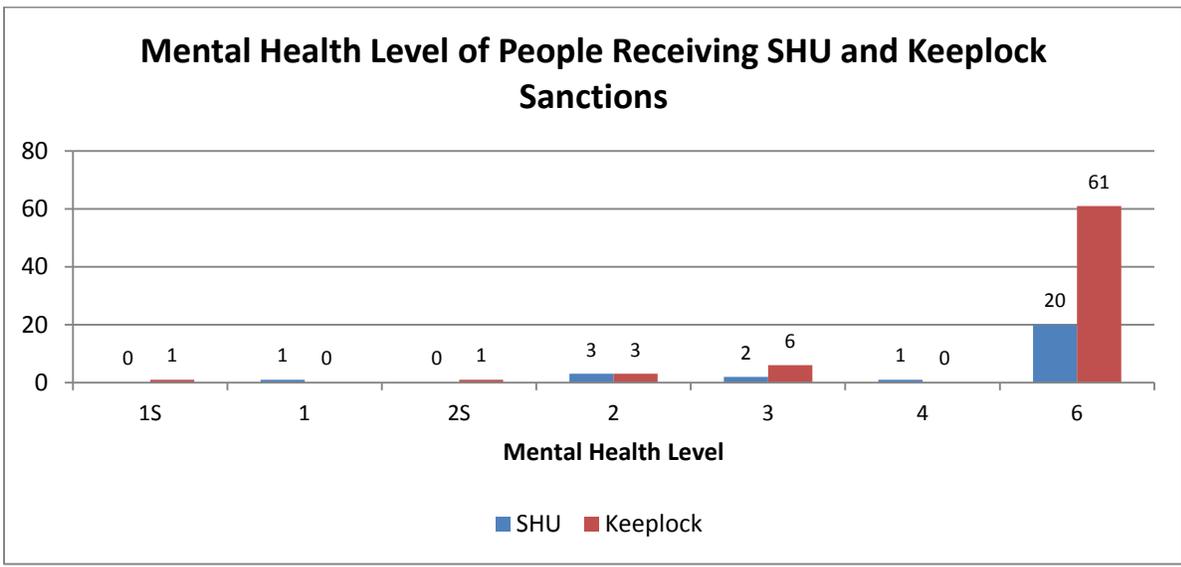
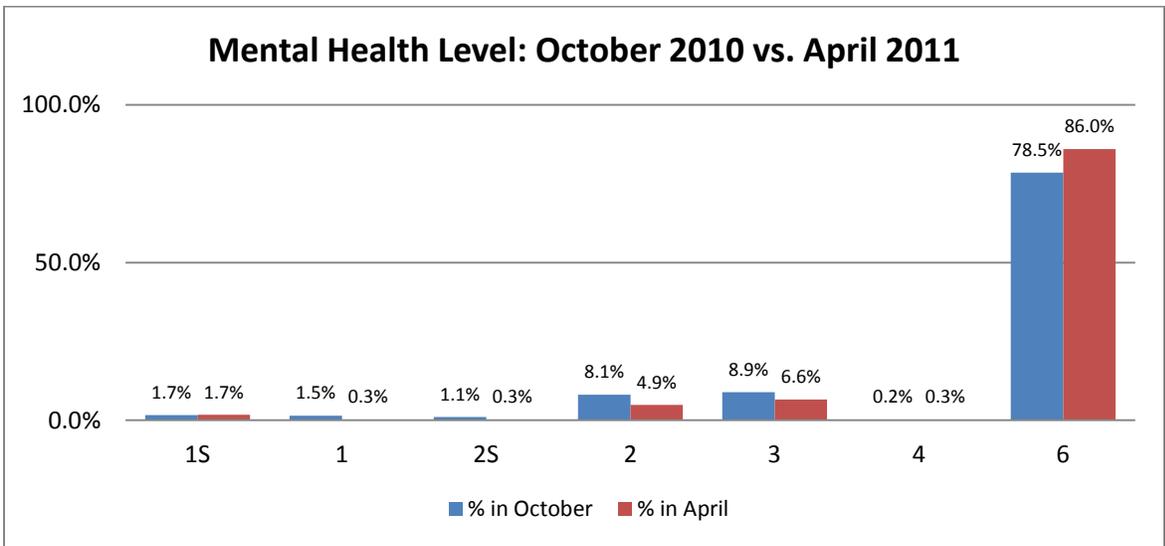
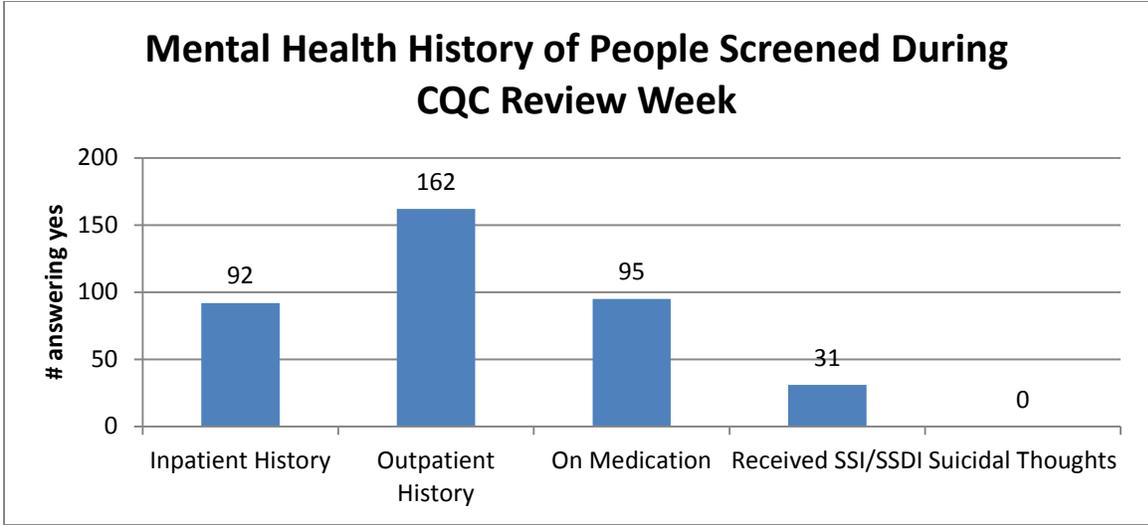
- 60 percent of the people who were incarcerated responding to the survey said they had been on psychiatric medication at some point in their life and 24 percent reported that they were taking medication at the time of the survey; and 26 percent said they had problems getting psychiatric medication while they were incarcerated.

Overall process:

- In surveys and interviews, DOCCS and OMH staff and inmates reported that the screening process was rushed
- The most common suggestions for improvement in the process varied by respondent:
 - OMH staff wanted more accurate information regarding the inmate, especially concerning medications;
 - DOCCS staff said more training about mental health and staff would help improve the reception screening process; and
 - People who were incarcerated wanted OMH staff to take their time and listen more carefully.

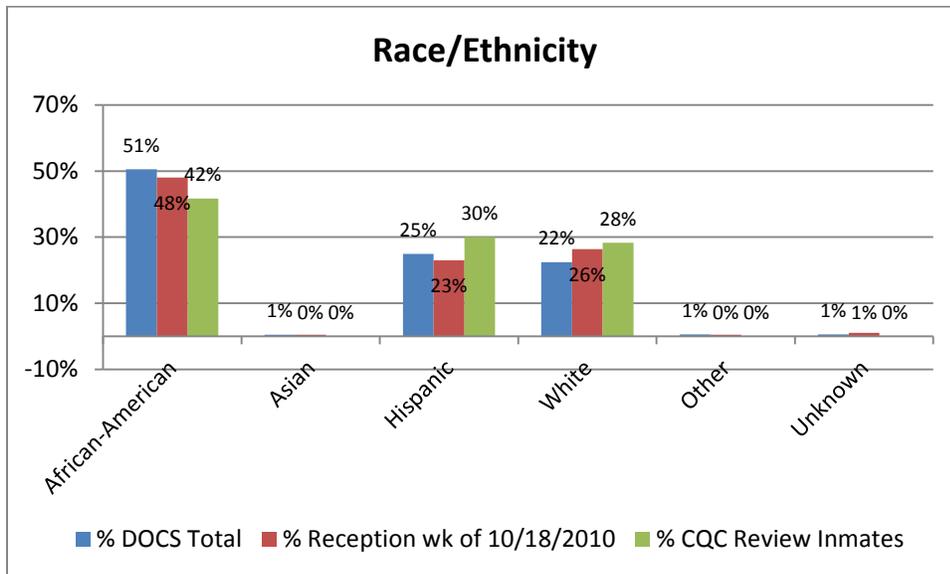
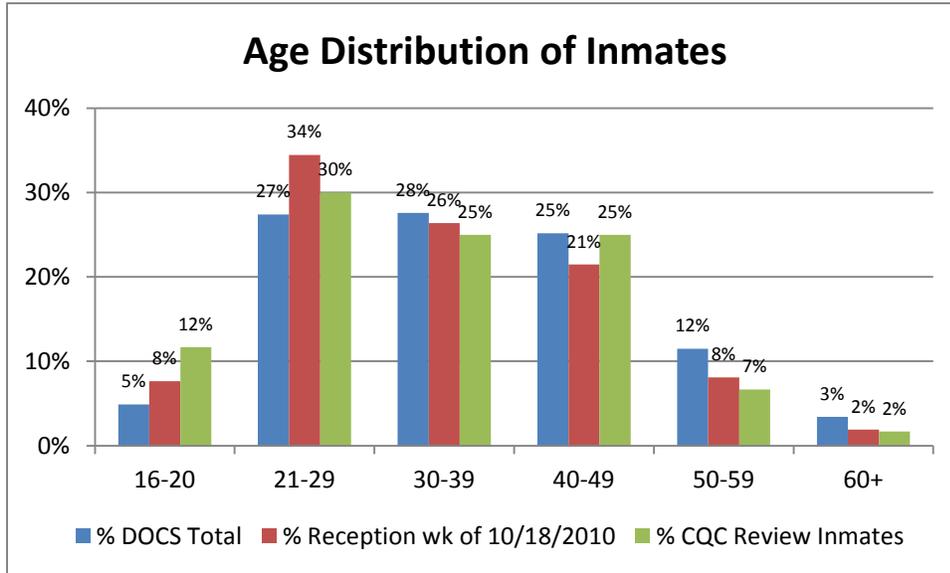
Appendix C –Caseload and Demographic Data

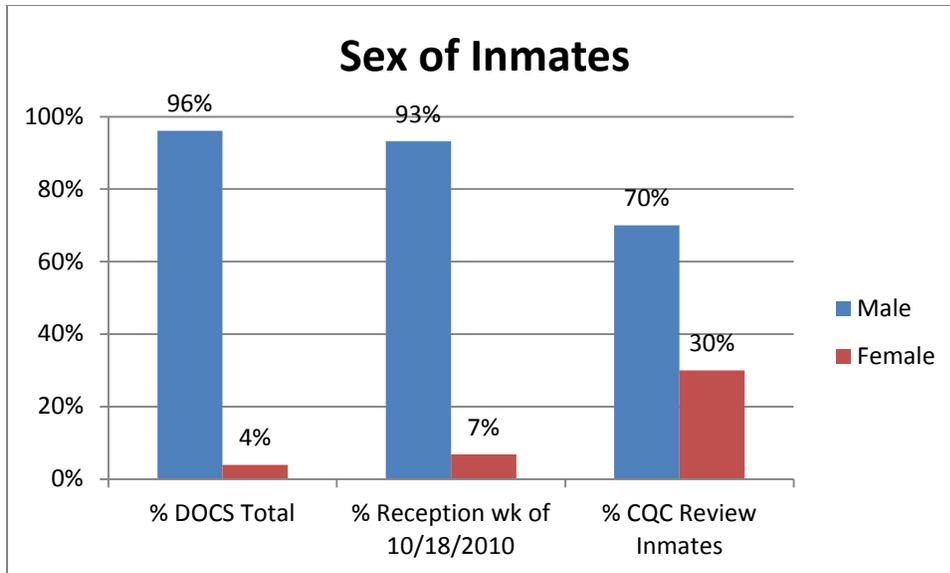




Demographic Information on All Inmates (N=470)

Age





Region of Commitment

Region	% of All Inmates	% of Oct. Reception Inmates	% of CQC Review Inmates
New York City	48%	25%	32%
Suburban NYC	12%	6%	3%
Upstate Urban	24%	16%	15%
Upstate Other	16%	12%	18%
N/A	0%	41%	32%



January 24, 2013

Michael Daly, Deputy Director
NYS Commission on Quality of Care
and Advocacy for Persons with Disabilities
401 State Street
Schenectady, NY 12305-2397

Dear Mr. Daly:

Thank you for sharing the findings and recommendations stemming from the Commission on Quality of Care and Advocacy for Persons With Disabilities' review of the reception center mental health screening process, and subsequent access to mental health services for inmates entering the New York State Department of Corrections and Community Services (DOCCS).

We are pleased to note the CQC findings that (1) OMH and DOCCS have designed and implemented a reception screening process which ensures that all inmates entering DOCCS at reception centers receive an assessment of mental health needs; (2) inmates determined to be in need of mental health services receive those services in compliance with OMH procedures and (3) many inmates report benefiting from the mental health services provided.

Regarding the recommendation that OMH collect more collateral information from others, especially family members, CNYPC Corrections-Based Operations (CBO) Policy 2.0, "Screened-Admitted to Services" requires that staff admitting inmates to active mental health services request psychiatric records from prior mental health providers. In addition, CBO Policy 2.1, "Family Input" states, "CNYPC Corrections-Based Operations will insure that, with proper patient authorization, an inmate-patient's family will be involved in his/her treatment process and receive requested information regarding the condition and mental health treatment of the inmate-patient." CNYPC recognizes the importance of obtaining treatment records from community providers and family members. To improve access to information on prior treatment episodes, CNYPC has initiated use of the OMH-developed PSYCKES database, which provides users with information on all Medicaid-reimbursed health care treatment for persons who received Medicaid-reimbursed behavioral health services in the community at anytime over the last five years. While PSYCKES provides only limited information on each episode of treatment, it informs efforts to locate treatment records maintained by community providers.

CNYPC routinely uses PSYCKES in the Serious Mental Illness Designation Process and as requested on a case-by-case basis. In February 2013, CNYPC will begin a 3-month pilot utilizing PSYCKES as part of the mental health screening process at reception and upon admission to crisis services at the Mental Health Satellite Unit located at Wende CF. Upon conclusion of the pilot, CNYPC will review the findings and implement PSYCKES system-wide.

Most inmates entering prison have been incarcerated in local jails while awaiting disposition of their cases. OMH is committed to ensuring that mental health treatment information is available from local jails prior to an inmate's transfer to DOCCS for continuity of care purposes. OMH routinely meets with the



NYS Commission of Correction, NYC Department of Health & Mental Hygiene and County Mental Health Directors to improve communication. As recently as 1/10/13, OMH and CNYPC met with NYC DHMH staff at Rikers Island to forward this effort. OMH will continue to address this need at the State and local level on an ongoing basis.

Family members are another rich source of mental health information, as well as support for service recipients. CNYPC is committed to involving family members in the treatment process, with consent of the inmate-patient. Obtaining consent can be a challenge as many inmate-patients do not want to involve their family in treatment. However, as discussed above, CNYPC clinicians discuss family involvement upon a person's admission to services and routinely thereafter (for those who do not initially grant consent). To further enhance the role of families in treatment, CNYPC has collaborated with the Urban Justice Center to develop and present in-service training for OMH staff focusing upon the successful engagement of family members. Additionally, CNYPC is creating a brochure to assist family members when a loved one is incarcerated.

Regarding the recommendation that OMH address the substance abuse needs of inmate-patients and work with DOCCS to expand substance abuse treatment programs for inmate-patients with co-occurring mental health and substance abuse disorders, DOCCS and OMH presently provide Integrated Dual Disorders Treatment (IDDT) programming in all Intermediate Care Programs. Thus, inmate-patients most in need of intensive mental health services have access to IDDT programming as recommended. IDDT is also available as indicated in Residential Mental Health Treatment Units. For other inmate-patients on the active mental health caseload, CNYPC clinicians identify and discuss substance abuse treatment needs during the course of the treatment planning process, and provide support for those inmate-patients participating in the variety of substance abuse treatment programs available in DOCCS facilities. Additional expansion of the IDDT programming available to inmate-patients will require significant resources and will be an agenda item for the DOCCS-OMH Quarterly Meeting scheduled during March 2013.

In discussion within the report, CQC mentions that both the Special Needs Unit (SNU) and the Community Orientation Reentry Program (CORP) are RMHTU's. Please be advised that each of these programs are not considered RMHTU's. The SNU program is not a dedicated mental health program and is operated by DOCCS. Inmates who are in SNU can be active on the mental health caseload and are provided services as outlined in the CNYPC CBO Policy Manual. The CORP Program is a 90-day reentry program for inmate-patients with serious mental illness returning to the NYC area located at Sing Sing CF. CORP provides daily programming that focuses on community reentry and includes group and individual therapy. A special component of CORP includes in-reach services from community-based mental health providers, peer support and an entitlement specialist.

Regarding the recommendation that OMH develop and implement a medication review protocol and track medication changes by facility on a quarterly basis to provide oversight to clinical staff, the CNYPC CBO Clinical Director utilizes data available in the CNYPC data system (CNet) to monitor psychiatric medication prescribing trends and to identify potential issues related to prescribing practices at specific mental health units. Additional oversight of prescribing practices is provided to individual psychiatrists and psychiatric nurse practitioners through CBO Regional Supervising Psychiatrists and through psychiatric peer reviews conducted semi-annually in conjunction with the CNYPC Quality Management Department. While CQC has identified what are described as frequent medication changes without

apparent clinical justification, OMH respectfully submits that changes in medication, particularly in the reception center population focused upon in this review, are the result of multiple factors and are well-justified. Such factors include the differences in prescribing practices and policies in county jails/Riker's Island and CNYPC CBO units. For example, inmates without Significant Mental Illness receiving Seroquel in a county jail will have their medication changed upon entering a reception center since Seroquel has exceptional status throughout CNYPC. Exceptional status requires clinical review and approval due to the drug being abused by the inmate population and the availability of equally effective, lesser-abused medications.

Another factor influencing the need to change medications is the changing mental status of inmate-patients entering DOCCS custody. Often, the change in environment leads to changes, both positive and negative, in mental status, which lead to the necessity to change medication in order to provide optimal care. CNYPC is dedicated to involving inmate-patients in their treatment, including in the medication management area. An important factor is the inmate-patient's request to have their medications changed which is reviewed during a private session with the prescriber. In an effort to maximize medication compliance, clinicians often change medications to address concerns raised by the inmate-patient as well as to prevent medication refusal when possible. In these cases, an equally clinically appropriate alternative is selected. The medical staff has been trained to continuously document the rationale for any change in medication. Additional emphasis will be evident with a planned statewide training initiative currently being developed for implementation in 2013.

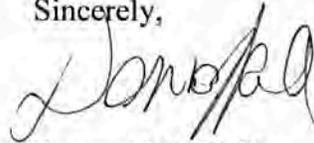
Regarding the recommendation to review decisions to terminate inmate-patients from the active mental health treatment caseload to ensure that those removed from the caseload are not in need of continued mental health services and all appropriate engagement strategies have been exhausted, CNYPC CBO staff consider termination from active mental health services according to CBO Policy 2.8, "Termination from Active Services." This policy states that an inmate-patient may be terminated from active mental health services when, "The presenting problem leading to the inmate-patient being admitted to services has been resolved, i.e. the disorder has remitted and treatment goals/discharge criteria have been met, or the inmate-patient has met the discharge criteria stated in his/her comprehensive treatment plan." Provisions in the policy insure that inmate-patients felt to be in need of services but refusing same remain on the caseload regardless of any non-compliance with treatment efforts. Upon termination from services, inmate-patients are instructed on the process for making a mental health referral should they require services in the future as well as a reminder of how to request treatment in a mental health emergency. Additionally, all terminations from services are reviewed by Unit Chiefs/Coordinators. OMH is confident that the review of terminations from services recommended by CQC routinely takes place in all CBO units.

Regarding the final recommendation that OMH maintain mental health staffing in all SHU and Long Term Keep Lock galleries to provide timely access to mental health treatment for inmates in segregated confinement: CNYPC CBO Policies 6.0, 6.1, 6.2, 6.3, & 6.4 describe the mental health services provided to inmates housed in SHU and LTKL galleries in Mental Health Service Level 1, 2, 3 & 4 facilities. Specifically, rounds on SHU and LTKL galleries are made by mental health clinical staff every business day and weekly by a Unit Chief/Unit Coordinator in MHSL 1 facilities, weekly by clinical staff and twice monthly by a Unit Chief/Coordinator in MHSL 2 facilities and at least twice monthly by mental health staff in MHSL 3 and 4 facilities. In addition, DOCCS security, civilian and medical staff receives mental health training annually and are present on SHU and LTKL galleries several times each day. Such staff routinely provides referrals to mental health for inmates requesting mental health contact during their

rounds. OMH is confident that all inmates housed in SHU and LTKL galleries have ready access to mental health services and that such services are available in a very timely basis. There is no consideration being given to any decrease in mental health staffing for SHU and LTKL services.

Thank you for your thorough review of reception services and resulting recommendations. OMH is confident that existing policies and procedures as well as initiatives planned for 2013 address your recommendations.

Sincerely,



Donna Hall, Ph.D.
Associate Commissioner
Division of Forensic Services

cc: Kristin Woodlock, Acting Commissioner, OMH
Brian Fischer, Commissioner, DOCCS
Diane Van Buren, Assistant Commissioner, DOCCS
Maureen Bosco, Executive Director, CNYPC
Marcia Fazio, Deputy Commissioner, Quality Management

**DEPARTMENT OF CORRECTIONS
AND COMMUNITY SUPERVISION**

THE HARRIMAN STATE CAMPUS – BUILDING 2

1220 WASHINGTON AVENUE

ALBANY, N.Y. 12226-2050

ANDREW M. CUOMO
GOVERNOR

BRIAN FISCHER
COMMISSIONER

January 23, 2013

Mr. Michael Daly
Deputy Director
NYS Commission on Quality of Care
& Advocacy for Persons with Disabilities
401 State Street
Schenectady, NY 12305-2397

Dear Mr. Daly:

Thank you for your report of the mental health screening process for offenders entering the New York State Department of Corrections and Community Supervision system.

Although your recommendations were directed to the Office of Mental Health, I wanted to take this opportunity to provide you with additional information regarding an offender's access to substance abuse treatment while incarcerated.

As you know, DOCCS operates the Alcohol and Substance Abuse Treatment (ASAT) programs for all offenders with an identified substance abuse need, including those on the OMH caseload. Offenders who have been designated by OMH as seriously mentally ill and who are housed in a Residential Mental Health Treatment Unit (RMHTU) can participate in the Integrated Dual Disorder Treatment (IDDT) program which is co-facilitated by DOCCS and OMH staff.

As of January 1, 2013, there were 8,300 offenders on the active OMH caseload, and 6,200 have been identified by DOCCS as having a substance abuse treatment need. Of these offenders with that substance abuse treatment need, almost forty percent have either satisfied the need or are in the program at this time.

Sincerely,



Brian Fischer
Commissioner

cc: Kristin Woodlock, Acting Commissioner – NYS Office of Mental Health
Donna Hall, Associate Commissioner – NYS Office of Mental Health



ANDREW M. CUOMO
GOVERNOR

STATE OF NEW YORK
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401 STATE STREET
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JOHN RYBALTOWSKI
ACTING CHAIR
BRUCE BLOWER
PATRICIA OKONIEWSKI
MEMBERS

February 19, 2013

The Honorable Brian Fischer
Commissioner
NYS Department of Corrections and Community Supervision Services
State Campus, Building 2
Albany, NY 12226-2050

Dear Commissioners Fischer:

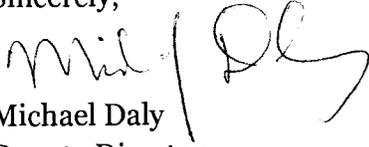
We have received your response to the review conducted by the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), of the mental health screening process for people entering New York State correctional facilities and their subsequent access to mental health services.

Thank you for the additional information you supplied regarding the number of people on the OMH caseload who have received substance abuse treatment. However, we remain concerned that substance abuse treatment needs do not appear, based upon the clinical documentation available to us for review, to be addressed as part of mental health treatment. Further, the Integrated Dual Disorder Treatment (IDDT) program is only available to people in Residential Mental Health Treatment Units (RMHTUs). Since the majority of people on the mental health case load are not in RMHTUs, we encourage you to explore an expansion of integrated treatment programs for people with co-occurring substance abuse and mental health disorders who reside in general population. There is a substantial body of evidence showing that integrated treatment for both mental health and substance abuse disorders is the most effective means to reduce the likelihood of relapse and recidivism. We were pleased to learn from OMH that expansion of the IDDT programming will be an agenda item for the DOCCS-OMH Quarterly Meeting in March 2013 and look forward to learning about the outcome of that discussion.

Under Article 6 of the Public Officers Law, final agency determinations are required to be available for public inspection. Our December 21 letter to you regarding our draft report, this letter, CQC's final report, and your agency response will be available for disclosure pursuant to the Public Officers Law. Material which is required to be kept confidential, or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to any such disclosure.

Thank you again for your cooperation during this review.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Daly". The signature is written in a cursive style with a vertical line separating the first and last names.

Michael Daly
Deputy Director

Enclosure

cc: Diane Van Buren
Kristin Woodlock
Donna Hall
Maureen Bosco
Marcia Fazio



ANDREW M. CUOMO
GOVERNOR

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JOHN RYBALTOWSKI
ACTING CHAIR
BRUCE BLOWER
PATRICIA OKONIEWSKI
MEMBERS

February 19, 2013

Donna Hall, Ph.D.
Associate Commissioner
Division of Forensic Services
NYS Office of Mental Health
44 Holland Avenue
Albany, NY 12229

Dear Dr. Hall:

We have received your response to the review conducted by the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), of the mental health screening process for people entering New York State correctional facilities and their subsequent access to mental health services.

We were pleased to learn about the initiatives currently underway to collect more collateral information from others, especially family members. These include using the OMH-developed PSYCKES database, which provides users with information on all Medicaid-reimbursed health care treatment for persons who received treatment in the community, as part of the mental health screening process at reception and upon admission to the crisis unit. Please keep us apprised about your progress with this initiative.

In addition to the efforts currently underway to involve family members in the treatment process, we offer two additional recommendations:

1. Require clinicians to document their discussions about family involvement in the mental health record.
2. Add the "Training Takeaways" provided at the family engagement training sessions conducted by OMH and the Urban Justice Center to the CNYPC operations manual. A copy is attached to this letter.

We were also pleased to hear that expansion of the Integrated Dual Disorder Treatment (IDDT) programming will be an agenda item for the DOCCS-OMH Quarterly Meeting in March 2013 and look forward to learning about the outcome of that discussion. We remain concerned that substance abuse treatment needs do not appear, based upon the clinical documentation available to us for review, to be addressed as part of mental health treatment. Further, the IDDT program is only available to people in Residential Mental Health Treatment Units (RMHTUs). Since the majority of people on the mental health case load are not in RMHTUs, we encourage you to explore an expansion of integrated treatment programs for people with co-occurring substance abuse and mental health disorders who reside in general population. There is a substantial body of evidence showing that integrated treatment for both mental health and substance abuse disorders is the most effective means to improve treatment engagement and reduce the likelihood of relapse and recidivism.

In your response to us, you describe a review process for both medication changes and termination from the mental health caseload that is not documented in the mental health records available to us for review. If this information is available in the C-Net database referenced in your letter, we should be provided with access to this data in future reviews.

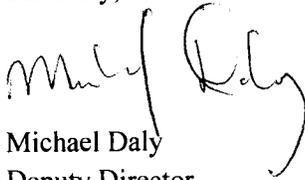
We are also interested in learning more about the "planned statewide training initiative" that will address medication issues. Please let us know when the training will be held and forward any training materials that will be used.

Finally, we are pleased to learn that there is no consideration being given to any decrease in mental health staffing for SHU and LTKL services.

Under Article 6 of the Public Officers Law, final agency determinations are required to be available for public inspection. Our December 21 letter to you regarding our draft report, this letter, CQC's final report, and your agency response will be available for disclosure pursuant to the Public Officers Law. Material which is required to be kept confidential, or which is protected from disclosure under the Public Officers Law or other laws will be redacted prior to any such disclosure.

Thank you again for your cooperation during this review.

Sincerely,



Michael Daly
Deputy Director

Enclosure

cc: Brian Fischer
Diane Van Buren
Kristin Woodlock
Maureen Bosco

Family Members: Active Partners in Mental Health Recovery Training Takeaways

Support Your Patient's Support System

- Ask each patient about family involvement in treatment when s/he begins receiving services. Consistent with your patient's wishes, have a comprehensive release of information signed that allows for communication with OMH staff at all prisons and CNYPC.
- Continue to revisit patient's interest in family member involvement during the course of treatment.
- When a family member contacts you, reengage the patient about consenting to the release of information.
- Alert family if patient decides to revoke consent of release of information.

Keep Families Informed

- Contact family when significant events occur.
- Renew contact with family after each transfer from prison to prison or hospital to prison.
- Explain OMH level changes to families.
- Provide family members with clear procedures:
 - For contacting unit chief and staff;
 - For filing complaints, including a process for families to receive a response; and
 - For reporting crises, including a process for families to receive a response.

Strive for Continuity of Care

- Obtain history of community treatment and medications.
- Contact previous providers.
- Provide consistent treatment across facilities.
- Avoid medication interruptions during transfers from prison to prison.

Value Your Patients

- Remember that you are treating a person, not just a prisoner, in need.
- Reflect on how much power you have and use it in the service of recovery – you can be a rare, positive force for change just by treating someone with respect.
- Recognize that the trauma of being incarcerated impacts a person's mental health.

Respect Their Family Members

- Work from a broad definition of family.
- Take information from and listen to family members, even if you aren't authorized by your patient to give them any information in return.
- Remember that family members are experts in their loved one's history.
- Keep in mind the multiple challenges families face in visiting their loved ones. For some, these barriers are insurmountable.
- Recognize that family members may be experiencing vicarious trauma and a deep sense of powerlessness from the experience of their loved one being in prison.

Take Care of Yourself

- Recognize that providing caring treatment in a punitive environment is daunting.
- Develop a support system that helps to rejuvenate you and enable you to continue to do this important work.