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Review of Residential Crisis Treatment Programs (RCTPs)

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New York State
Commission on Quality of Care
and Advocacy for Persons with Disabilities

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Executive Summary

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 the responsibility to monitor the quality of mental health care provided to inmates in correctional facilities operated by the New York State Department of Correctional Services (DOCS). In order to carry out this responsibility, the Commission will conduct a series of systemic reviews of mental health programs in state-operated correctional facilities. This review of Residential Crisis Treatment Programs (RCTPs) is the first in that series of systemic reviews.

Inmates in need of immediate mental health evaluation, and/or observation and treatment, are required to be transferred to 1 of 16 RCTPs operating in DOCS facilities. RCTPs are intended to house inmates in a safe environment while mental health and DOCS staff observe and monitor them. After observation and interviews with the inmate, mental health staff determine whether or not the inmate can return to DOCS housing or needs inpatient care at the Central New York Psychiatric Center (CNYPC). The purpose of the Commission's review was to assess how RCTPs serve inmates in need of mental health evaluation, observation and treatment.

The Commission reviewed utilization data from eight correctional facilities serving over 4,500 inmates annually, three months of mental health and correctional records for 59 inmates, policies, procedures, training curricula for corrections and mental health staff working in RCTPs, conducted private interviews with 52 inmates, and received over 100 surveys from inmates and staff. New York State DOCS and Office of Mental Health (OMH) staff at the agencies' central offices and at the eight correctional facilities provided a high level of cooperation throughout the review process.

Summary of Findings:

- Most of the inmates transferred to RCTPs had a serious mental illness and a high level of mental health needs. Many inmates also had co-occurring substance abuse disorders.

- The majority of inmates transferred to the RCTP experienced a mental health crisis or exhibited behavior or made statements that indicated they may be at risk for self-harm. The RCTP was also used for respite and as a re-entry point for inmates returning from CNYPC. All of these uses can be beneficial to the inmate's mental health.

- Transfer to the RCTP was helpful for many inmates, but the benefit was not apparent for all inmates, and a few may have benefitted more by transfer to CNYPC for inpatient care.

- Most inmates are transferred into observation cells, rather than to dorm beds, and this practice varied by facility.

- Documentation completed by DOCS and OMH was not always complete. The overall quality of documentation varied by facility and all facilities had incomplete nursing notes and monitoring charts.

Summary of Recommendations

Based upon the findings from this review, the Commission recommends the following to OMH and DOCS:

1. Continue to monitor the mental health caseload to ensure that all inmates who have a diagnosis that is defined in the SHU Exclusion Law as a serious mental illness have the required "S" designation.

2. Continue to review and expand DOCS and OMH substance abuse treatment programs to ensure that inmates with serious mental illness have timely access to substance abuse treatment.

3. Maximize the therapeutic nature of the RCTP and decrease the perception that RCTP is punishment by:

    - Ensuring that the restriction and restoration of amenities is based on an individualized assessment of each inmate with an emphasis on the restoration of amenities – especially underwear, clothing and eating utensils, as soon as clinically appropriate;

    - Monitoring the temperature in observation cells to ensure that it is comfortable for inmates, especially those in suicide prevention smocks;

    - Banning the use of punitive measures such as using fans as a form of inmate management; and

    - Ensuring that all corrections officers working in RCTPs, including relief staff, receive additional mental health training.

4. Revise policies and procedures to include transfers from CNYPC or for inmates in need of respite from environmental stressors. The Commission recommends that such policies and procedures acknowledge that there may be less risk of self-harm for these inmates and housing and access to amenities should be based on least restrictive principles while they are in the RCTP.

5. Improve documentation in:

    - Nursing assessments and progress notes;
    - RCTP monitoring forms;
    - Consultation with CNYPC for length-of-stay of seven days or more; and
    - Security log books – clearly identify watches, when mental health staff are on units and document mental health staff review of suicide watch log books.

6. Reconsider the recent OMH decision to identify the reason for transfer only in cases of self-harm or assaultive behavior on RCTP monitoring forms.

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Introduction

Chapter 1 of the Laws of 2008 authorized the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (hereinafter referred to as the Commission) to monitor the quality of mental health care provided to inmates in State-operated correctional facilities. The legislative intent articulated in Chapter 1 is to balance the mental health treatment needs of inmates with the need to maintain safety in correctional facilities. The legislative findings of this law state, in part, that "inmates with serious mental illness should be served by improved access to mental health treatment during incarceration."

The Commission is undertaking a range of activities to monitor the quality of and access to mental health services in correctional facilities, including a multi-phase review of mental health programs currently operating in correctional facilities. The Commission's first review is of the Residential Crisis Treatment Programs (RCTPs).

Inmate Mental Health Levels of Need

Level 1 – major/serious mental illness, active symptoms, six months of instability.

Level 2 – major serious/mental illness, no significant active symptoms, treatment and medication-compliant for 1 year, 6 months stability.

Level 3 – short-term medication needs or can function in setting with part-time mental health staff.

Level 4 – mild disorders, no medication needs.

Level 6 – does not require mental health services.

Mental Health Services in State-Operated Correctional Facilities

Upon entry into the correctional system, all inmates are assessed for mental health needs by clinical staff employed by the New York State Office of Mental Health (OMH)[1]. The inmate is assigned a level of mental health need, and that level is one of the criteria used to determine the correctional facility in which the inmate will be housed. Inmates who are not on the mental health caseload may be referred to mental health services at any time by anyone, including Department of Correctional Services (DOCS) staff, the inmate, another inmate, or a family member.

Mental Health Classification Levels of NYS Correctional Facilities

Level 1 – full-time mental health staff, treatment for major mental health disorders and specialized services including RCTPs.

Level 2 – full-time mental health staff, treatment for inmates with less acute mental health disorders.

Level 3 – part-time mental health staff, treatment and medication for moderate mental health disorders.

Level 4 – part-time mental health staff, treatment for limited interventions, no medication monitoring.

Level 6 – no on-site mental health staff.

There are less than 60,000 inmates housed in State-operated correctional facilities and about 15 percent, or 8,500 inmates, are on the mental health caseload and receive mental health care provided by clinical staff employed by OMH. Approximately five percent, or 3,000 inmates, are identified as seriously mentally ill, a designation that provides inmates with access to a "heightened level of care" if they receive a disciplinary sanction of 30 days or more in a Special Housing Unit (SHU) or in Keeplock.

Over 1,000 residential mental health beds are operated by DOCS and OMH in correctional facilities. Most of the inmates on the mental health caseload are housed in general population. Inmates

[1] Universal screening began in December 2007 as a result of the DOCS/OMH Private Settlement Agreement with Disability Advocates, Inc.

in general population participate in programming provided by DOCS and receive mental health services according to their mental health needs.

In addition, the Central New York Psychiatric Center (CNYPC) operates a 210 bed maximum security inpatient facility in Marcy, New York. CNYPC is the only facility where male and female inmates may be involuntarily hospitalized.

The Role of the Residential Crisis Treatment Program (RCTP) in Correctional Facilities

DOCS policies require that any inmate in need of immediate mental health evaluation, and/or observation and treatment, be transferred to 1 of 16 RCTPs operating in DOCS facilities[2]. RCTPs are intended to be "the briefest possible, comprehensive treatment experience in an environment specifically designed to ensure safety[3]." Inmates transferred to the RCTP may be housed in observation cells with limited access to personal items or in a dormitory setting.

Inmates are transferred out of RCTPs when the crisis has been resolved, or a psychiatric assessment determines the inmate is capable of meaningful participation in programming or needs inpatient treatment at CNYPC. Over 5,500 inmates are transferred into RCTPs on an annual basis. The purpose of the Commission's review was to assess how RCTPs serve inmates in need of mental health evaluation, observation and treatment.

Scope of Review

The Commission's review of RCTPs encompassed:

- Utilization data from eight correctional facilities: The Commission received information[4] about all inmates transferred during the month of June 2009 into RCTPs at six correctional facilities for men (Attica, Clinton, Downstate, Great Meadow, Sing Sing and Wende) and two correctional facilities for women (Albion and Bedford Hills). In June 2009, there were a total of 365 transfers into these facilities generated by 293 individual inmates. There are over 4,500 transfers into RCTPs in these eight facilities annually[5].

- Three months of mental health and correctional records from 59 inmates: Most of the inmates selected for record review were selected from the group of inmates transferred into RCTPs in June 2009. The Commission also asked OMH to select two inmates from each facility who they believed were successfully treated in RCTP. Mental health and corrections records were reviewed for the two months leading up to transfer to the RCTP and one month after transfer

[2] RCTPs are in the following maximum and minimum security facilities: Attica, Albion*, Auburn, Bedford Hills, Clinton, Downstate, Elmira, Fishkill*, Five Points, Great Meadow, Marcy, Mid-State*, Sing Sing, Southport, Sullivan, Wende.
* medium security prison

[3] Memo to CQC from OMH regarding RCTP Review CQC Draft Findings. May 4, 2010.

[4] Name, DIN, race/ethnicity, instant offense, language, mental health level (current and at time of transfer in and out of RCTP), age, location transferred to and from, length of stay, mental health observation location (observation cell or dorm bed), reason for transfer to RCTP and the date of transfer.

[5] Source: DOCS – between June 08-09 there were 4,646 transfers.

out of the RCTP[6]. These 59 inmates generated 120 transfers into the RCTP during the three month time period.

- Private interviews with inmates: The Commission invited all inmates selected for the review to a private interview, away from DOCS or OMH staff. Inmates were not required to participate and 52 inmates agreed to be interviewed.

- Inmate and staff surveys: Surveys soliciting individual opinions about the mental health care and treatment provided in RCTPs were sent to all inmates transferred into RCTPs in the review facilities in June as well as the OMH and DOCS staff working in RCTPs. The Commission received 123 surveys from inmates and staff[7].

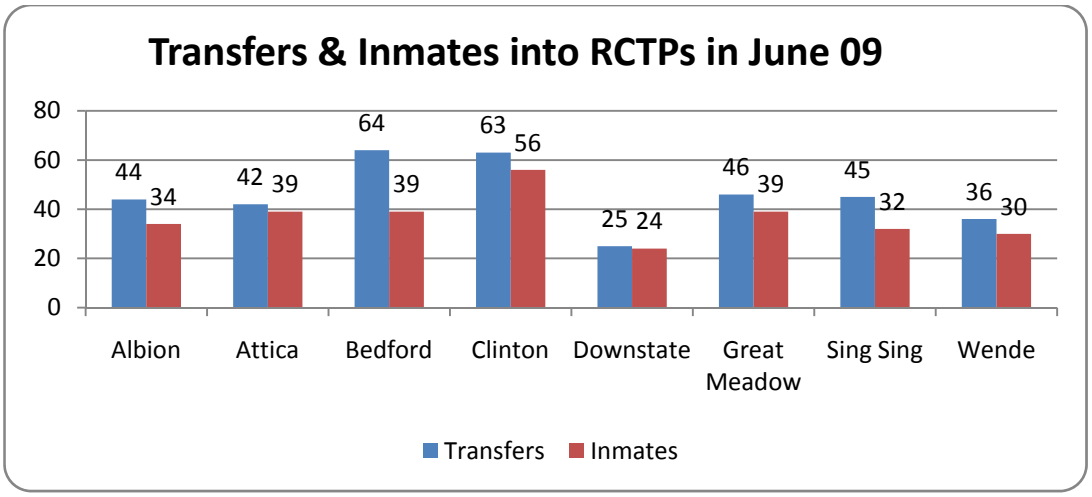
RCTP Surveys Mailed & Received			
Survey Recipient	**Surveys Mailed**	**Received**	**Percent**
Inmates	238	105	44%
OMH Staff	16	10	63%
DOCS Staff	131	8	6%
Total	385	123	32%

- Policies, procedures, training curricula: OMH and DOCS policies, procedures and training curriculums applying to RCTPs were reviewed.

This review is based on a specified period of time at selected correctional facilities. The purpose of the review is to identify systemic issues. As a result, the only facility-specific information included in this review is utilization data. Facility-specific case information and inmate and staff opinions about mental health care in RCTPs have been omitted to ensure confidentiality.

[6] Some of the inmates selected by OMH for review were not transferred in June 2009. The entire time period that records were reviewed spanned from 2008 to October 2009.

[7] Surveys were received from inmates who were served in all eight of the correctional facilities included in the review. Almost thirty percent of the inmates completing the surveys were transferred to the RCTP from another correctional facility. Five surveys (out of a total of ten possible) were received from inmates whose primary language was Spanish. OMH and DOCS staff from six different facilities completed surveys.

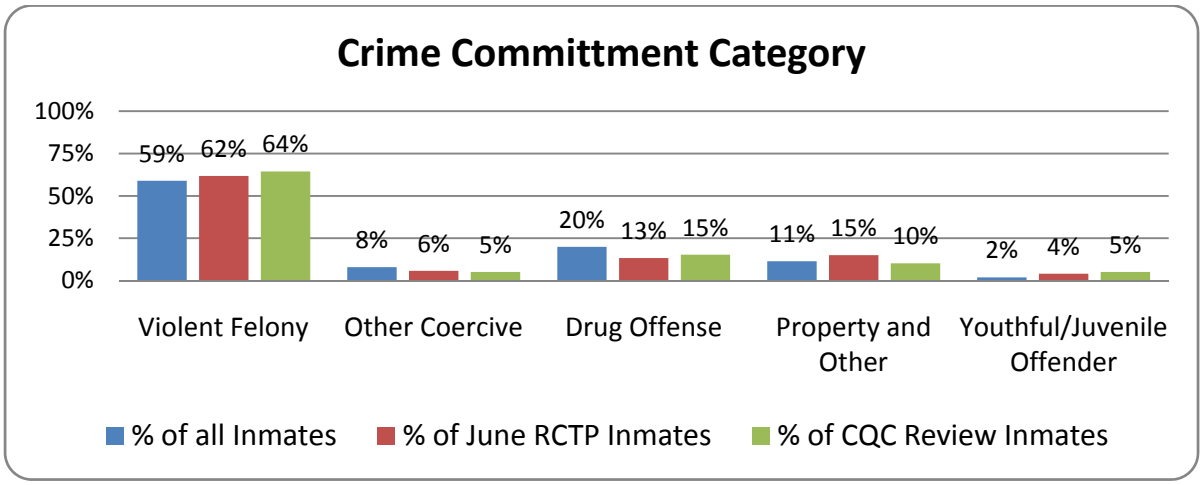


The chart above shows the number of transfers (N=365) and inmates transferred (N=293) by facility. There were 54 inmates who had more than one transfer to a RCTP in June. Over 40 percent (23) of inmates with more than one transfer into the RCTP were transferred from an observation cell into a dorm bed.

Demographic Information

Inmates transferred into the eight RCTPs in the Commission's review were similar to all inmates in New York State correctional facilities in age and race and ethnicity. The percentage of women transferred into RCTPs (25 percent) was higher than the percentage of women in DOCS custody (4 percent)[8].

Crime Commitment Data



Over half of the inmates housed in correctional facilities and transferred to RCTPs have been convicted of a violent felony offense (murder, rape, burglary, etc.).

[8] See Appendix 1 for complete demographic information.

Mental Health Status of Inmates Transferred to the RCTP

Diagnosis	Inmates Transferred in June '09 (N=293)	CQC Review Inmates(N=59)
Schizophrenia & Other Psychotic Disorders	79 (27%)	22 (37%)
Major Depressive Disorders	46 (16%)	12 (20%)
Anti-Social Personality Disorders	40 (14%)	8 (14%)
Adjustment Disorders	35 (12%)	4 (7%)
Anxiety Disorders (includes Post-Traumatic Stress Disorder)	21 (7%)	3 (5%)
Other	72 (24%)	10 (17%)

"S" Designation

Inmates who are determined to have a serious mental illness, or "S" designation as it is referred to in the correctional system, are provided with access to a "heightened level of care"[9] if they receive a disciplinary sanction of 30 days or more in a Special Housing Unit (SHU). The SHU Exclusion Law defines what constitutes the "S" designation for inmates. Inmates who have received certain diagnoses (such as schizophrenia, psychotic disorders and major depressive disorders) are required to have an "S" designation[10].

The Commission found that 30 inmates transferred into these eight RCTPs in June did not have an "S" designation even though they had a diagnosis that is identified in the SHU exclusion law as criteria for having an "S" designation. When this issue was brought to the attention of OMH, they took action to ensure that each inmate received the appropriate designation and established a monitoring system to prevent future discrepancies. In addition, OMH will engage in periodic reviews of the designation status of the entire caseload.

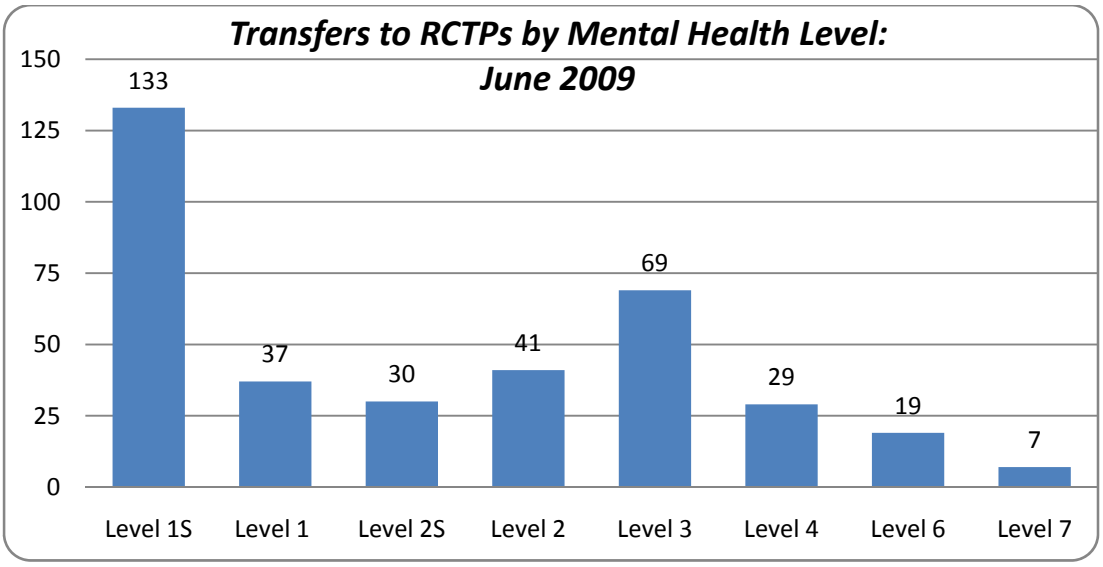
Mental Health Level

Almost half of the transfers into RCTPs were generated by inmates who had a mental health level of 1 or 1S, indicating that they had a major/serious mental illness with active symptoms. Inmates with no current mental health needs (level 6) generated five percent of the transfers into the RCTP in June 2009[11].

[9] Four hours of out-of-cell mental health and DOCS programming in addition to one hour for exercise, five days a week.

[10] See Appendix 2 for a complete definition.

[11] Level 7 is used at Downstate when they have not yet determined an inmate's mental health level.



While in the RCTP, 67 inmates had their mental health level changed, 17 had their mental health level lowered and 3 inmates had their "S" designation removed. Two of those inmates were diagnosed with anti-social personality disorder which is not an "S"-defined diagnosis in the SHU Exclusion Law. One inmate whose "S" designation was removed had a diagnosis of Schizophrenia. OMH has subsequently rectified this situation.

Medication

The Commission's survey of inmates asked whether they were taking mental health medications, and whether they knew how the medication is supposed to work and what the side effects were. Seventy percent of the inmates responding to the survey said they were taking mental health medication, but only 44 percent of those who were taking mental health medication knew how it worked and what the side effects were.

Substance Abuse

The case records of many of the 59 inmates selected for review revealed that almost half (49 percent) of those inmates had an additional Axis I diagnosis[12] that was substance abuse-related (e.g., cocaine dependence) and 76 percent of the inmates included in the Commission's review either had an Axis I diagnosis or a history of substance abuse.

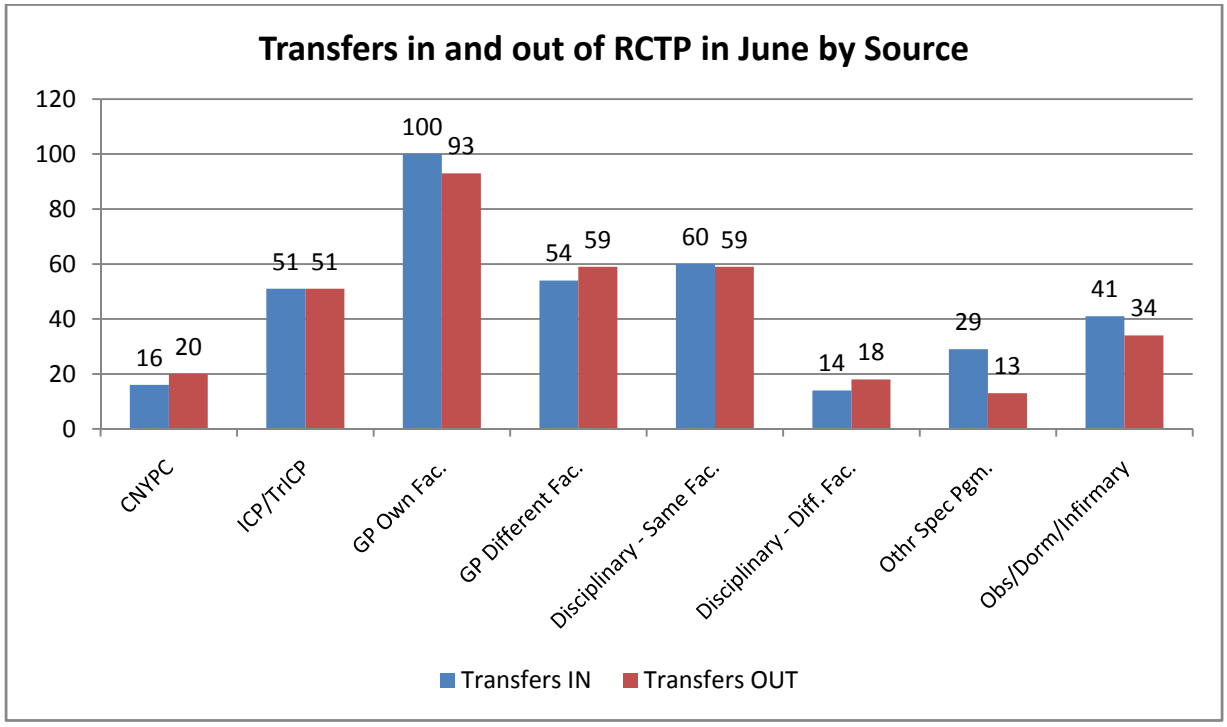
The Commission reviewed treatment plans of inmates with Axis I substance abuse diagnoses to see how the condition was being treated. More than half (15) of the 26 inmates with an Axis I substance abuse-related diagnosis had their substance abuse treatment "deferred to DOCS" in their treatment plans. All but 1 of the 15 inmates whose substance abuse treatment was deferred to DOCS had a mental health level of 1, 1S or 2S, indicating that they also have a major/serious mental illness with active symptoms

[12] The Diagnostic and Statistical Manual published by the American Psychiatric Association organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability. Axis I includes major mental disorders, and learning disorders.

requiring treatment. In addition, there were three inmates in the review who had active substance abuse issues that were of concern to them; one of whom was transferred into the RCTP after accidently overdosing while attempting to get high[13].

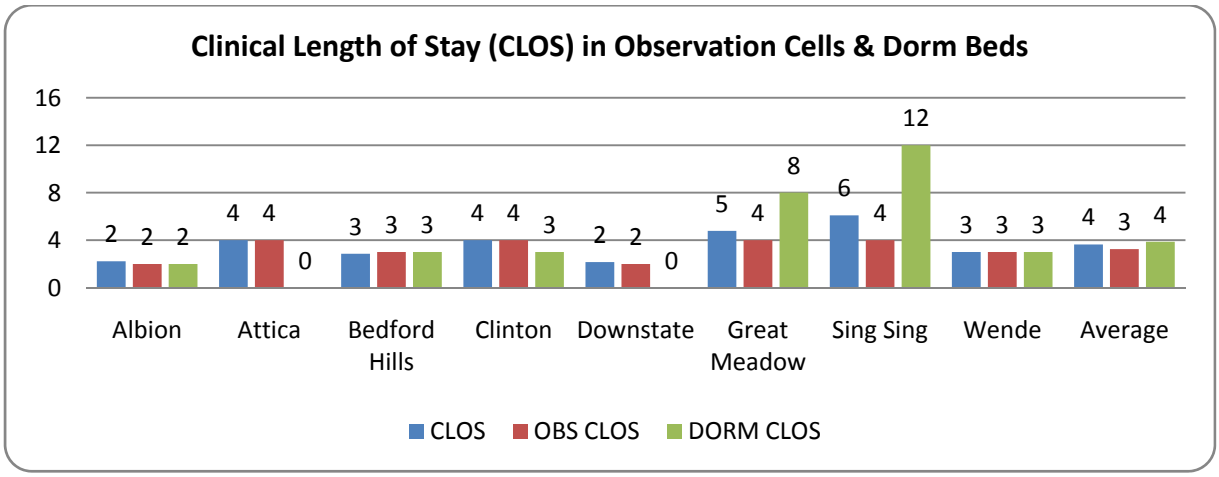
DOCS and OMH reported to the Commission that due to the prevalence of co-occurring substance abuse disorders among inmates on the mental health caseload, they have developed specialized programming for inmates housed in Intermediate Care Programs, Behavioral Health Units and the new Residential Mental Health Unit. In addition, there is an Alcohol and Substance Abuse Treatment Program for the Mentally Ill offered at Mid-State Correctional Facility for males and Bedford Hills for females[14]. The Commission supports these efforts and encourages further development and expansion of treatment programs targeted toward inmates with mental illness and a co-occurring substance abuse disorder, especially those inmates housed in general population.

Transfer and Discharge Source



Over 40 percent of inmates transferred into the eight RCTPs came from and returned to general population in the same correctional facility as the RCTP or in another correctional facility. Twenty percent of the inmates came from and returned to a disciplinary setting[15] and five percent of inmates were transferred to CNYPC for inpatient care. Almost a quarter of the inmates were transferred into the RCTP from another correctional facility or CNYPC.

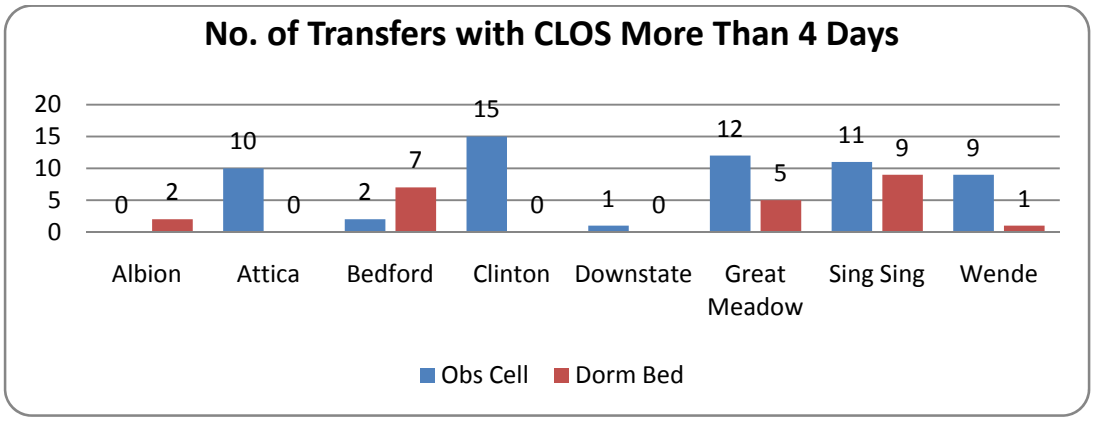
[13] One inmate was hospitalized after overdosing in September 2009, one was concerned about relapsing upon release from prison and one was transferred to the RCTP in June after accidently overdosing.
[14] See Appendix 3.
[15] Includes SHU, Keeplock, BHU, TBU.



Clinical Length of Stay (CLOS)

The 2007 Private Settlement Agreement with Disability Advocates, Inc. sets the goal of a four-day maximum for the length of stay in an observation cell[16]. The chart above shows the average clinical length of stay by facility in observation cells and dorm beds.

Even though the average CLOS in an observation cell was four days or less at all facilities except Great Meadow, there were 84 inmates transferred to the RCTP in June who remained in there for over four days. Sixty of those inmates who had a CLOS of more than four days were in observation cells and 24 were in dorm beds.



There were seven inmates who were in an observation cell for ten days or more in June, one of whom was in an observation cell for 25 days. There were five inmates who were in dorm beds and had a CLOS that was more than 20 days in June.

[16] OMH defines Clinical Length of Stay (CLOS) as the time period an inmate remains in the RCTP for clinical reasons. There are occasions when an inmate is ready for transfer out of RCTP but housing is not available in DOCS. The Commission compared the actual number of days that inmates were in RCTP and found no significant differences between the two.

Review Findings

1. Reason for Transfer to the RCTP

The CNYPC Corrections-Based Operations Manual[17] states that observation cells should be utilized only for inmates who may be psychiatrically unstable, unpredictable and/or a danger to themselves or others. Dorm beds are used to safely house inmate-patients for the purpose of observing and monitoring behavior.

The Commission found that the majority of inmates who are served in the RCTP are experiencing a mental health crisis or have exhibited behavior or made statements that indicate the person may be at risk for self-harm.

The RCTP is also used for respite and as a re-entry point for inmates returning from CNYPC. Both of these uses can be beneficial to the inmate's mental health. A transfer to the RCTP to prevent an inmate's mental health from deteriorating to the point that they may require inpatient hospitalization and/or harm themselves or others is beneficial for the health and safety of inmates and staff. Further, transfer to the RCTP upon return from CNYPC may assist the inmate's return to the correctional facility.

However, there is no policy in place for the use of the RCTP for transfers from CNYPC or for inmates in need of respite from environmental stressors. Due to the nature of these types of transfers, it may be appropriate to develop policies and procedures for returns from CNYPC or respite. Such policies and procedures should address the fact that there may be less risk of self-harm for these inmates.

As a result, the Commission recommends that OMH revise policies and procedures to include transfers from CNYPC or for inmates in need of respite from environmental stressors. The Commission recommends that such policies and procedures acknowledge that there may be less risk of self-harm for these inmates and housing and access to amenities should be based on least restrictive principles while they are in the RCTP.

These findings are based on the following:

Reasons for transfer to the RCTP

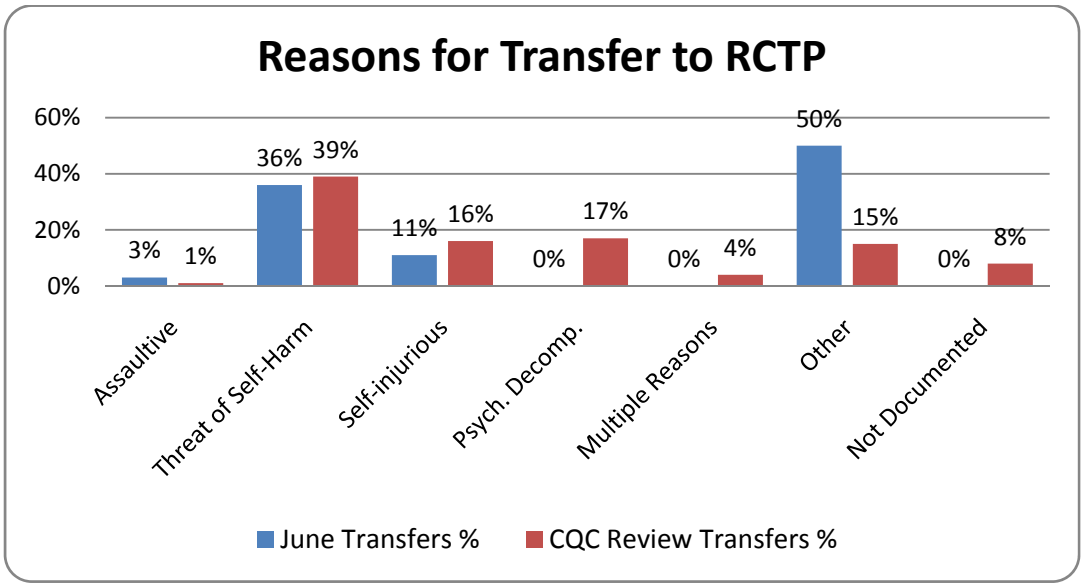
June 2009 utilization data shows that half of the transfers were due to an "other mental health reason" and less than half of the transfers were due to threats of self-harm and self-injurious behavior. Some portion of "other" in the June utilization data reported to the Commission may include psychiatric decompensation[18].

The 59 inmates whose files were reviewed by the Commission contained documentation for 120 transfers during the three months reviewed. Over 50 percent of these transfers to the RCTP were due

[17] CNYPC Corrections-Based Operations Manual. Chapter 4 – Crisis Intervention Services, #4.0 Observation Cells and #4.2 RCTP Dorm.

[18] CNYPC eliminated the category of "psychiatric decompensation" as a reason for transfer from the RCTP monitoring form in August 2009.

to a threat of self-harm or self-injurious behavior, 17 percent were due to psychiatric decompensation[19], and 15 percent of the inmates were transferred due to an "other mental health reason."



The category of "other mental health reason" was used for inmates in the record review in the following instances: when mental health staff was concerned about an inmate's reaction to some bad news, upon return from CNYPC and, in one or two cases, in error (i.e., threatened self-harm but "other" was checked).

Progress Notes

The nursing assessments and progress notes reviewed documented that most inmates had either stated that they wanted to harm themselves, had engaged in self-injurious behavior, or OMH or DOCS staff were concerned about the mental health of the inmate at the time of transfer. There were some documented instances of using RCTP as respite at one correctional facility serving women.

Inmate Survey and On-Site Inmate Interview

The majority of inmates responding to the inmate survey (80 percent) and on-site inmate interview (57 percent) reported they were experiencing a crisis at the time of transfer and/or had concerns about their mental health when they were transferred to the RCTP.

Staff Survey

The OMH staff who responded to the Commission's survey indicated that RCTPs serve a diverse group of people. Staff reported that some inmates need mental health intervention for psychiatric stabilization, some require respite from environmental stressors and others use the RCTP in pursuit of secondary gain which can be artfully masked.

[19] Source: RCTP Observation Monitoring forms were the source of the transfer information for inmates included in CQC's review, or, if the inmate was transferred directly to a dorm bed (N= 11) or the infirmary (n=1), progress notes were used as the source.

2. Outcome of Transfer

The Commission reviewed survey answers, inmate interviews and case files to determine whether or not transfer to the RCTP is beneficial to an inmate's mental health. This data indicates that transfer to the RCTP was helpful for some inmates, but the benefit was not apparent for all inmates, and a few inmates may have benefitted more by transfer to CNYPC for inpatient care.

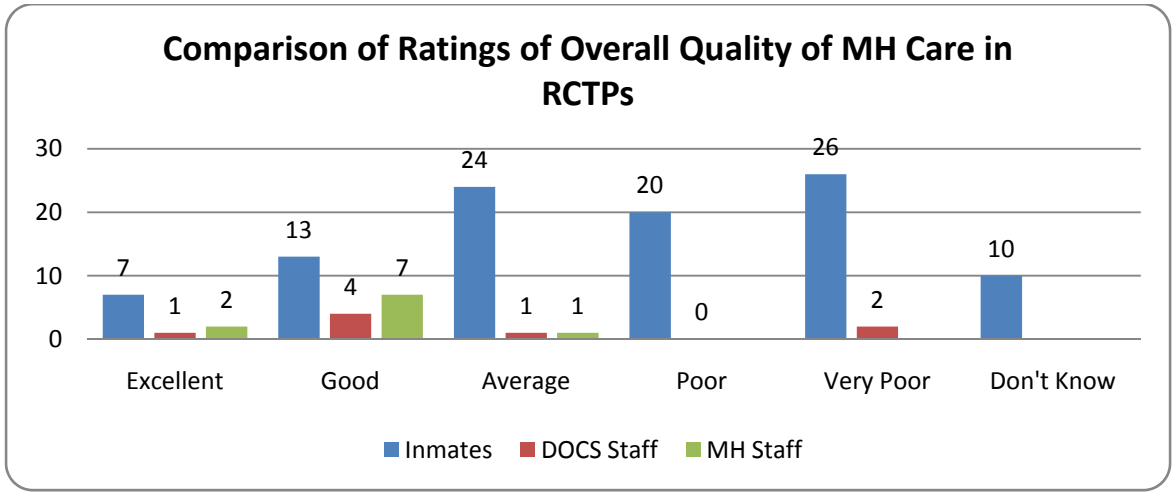
Overall, inmates believed they were treated well by OMH and DOCS staff working in the RCTPs. In addition, the staff working in the RCTPs reported that OMH and DOCS staff worked well together and believed this had a positive impact on the mental health care inmates receive in RCTPs.

However, many inmates view the RCTP as punishment. The Commission recommends that DOCS and OMH take the following steps to change this:

- ensure that the restriction and restoration of amenities is based on an individualized assessment of each inmate with an emphasis on the restoration of amenities – especially underwear, clothing and eating utensils, as soon as clinically appropriate;
- monitor the temperature in observation cells to ensure that it is comfortable for inmates, especially those in suicide prevention smocks;
- ban the use of punitive measures such as turning fans on inmates as a form of inmate management; and
- ensure that all corrections officers working in RCTPs, including relief staff, receive additional mental health training called for in the SHU Exclusion law. Corrections officers spend the most time with inmates while they are in RCTP.

Survey and Interview Results

The Commission's survey asked inmates and staff to rate the overall quality of mental health care provided in the RCTP. Staff rated the quality of mental health care better than the inmates. Care was rated as excellent or good by the majority of staff while the majority of inmates rated the overall quality of mental health care as poor or very poor.



Staff Survey Responses

OMH staff rated the quality of mental health care in the RCTP favorably. OMH staff attributed the quality of mental health care to a good working relationship with DOCS staff. The few DOCS staff that responded to the survey also rated the relationship favorably. The majority of OMH staff thought corrections officers were generally knowledgeable about mental health issues but noted that relief or "swap" staff were often less knowledgeable about mental health issues. One of the corrections officers wrote that OMH staff did their best to help him understand the mental health needs of inmates but more training would be helpful.

Inmate Responses (Survey and Interview Results)

Overall quality of mental health care:

The inmates who characterized the quality of mental health care as good or excellent reported that the treatment was helpful and the staff treated them with care and concern. Those who believed the quality of mental health care was poor or very poor said the mental health staff did not listen to what they were saying and treated them poorly.

More than half of the inmates interviewed by Commission staff reported that they thought being in the RCTP helped them[20]. Those who believed that the RCTP helped said that they were able to get some rest, think about their problems and talk to a doctor. One inmate thought it helped prevent him from "doing more damage."

Those inmates who believed the RCTP did not help viewed the observation cell as punishment and thought that mental health staff should be available more often to speak with them. Some inmates commented that when they were in an observation cell there was nothing to take their mind off their problems.

Inmates who were transferred to the dorm had a more favorable opinion about their experience in the RCTP. These inmates stated that there were things to do in the dorm, such as watching T.V. or doing puzzles, and some believed the corrections officers treated them better in the dorm. However, there were some inmates who reported that they did not feel safe in the dorm bed and preferred an observation cell.

The RCTPs at correctional facilities serving women received higher satisfaction ratings from inmates responding to the survey than the RCTPs serving male inmates received[21].

[20] 49 inmates answered the question "Did being in the RCTP help you?" 29 of those inmates said yes or probably, 17 said no, 3 weren't sure and 3 did not respond to this question.

[21] Albion and Bedford Hills are correctional facilities for women.

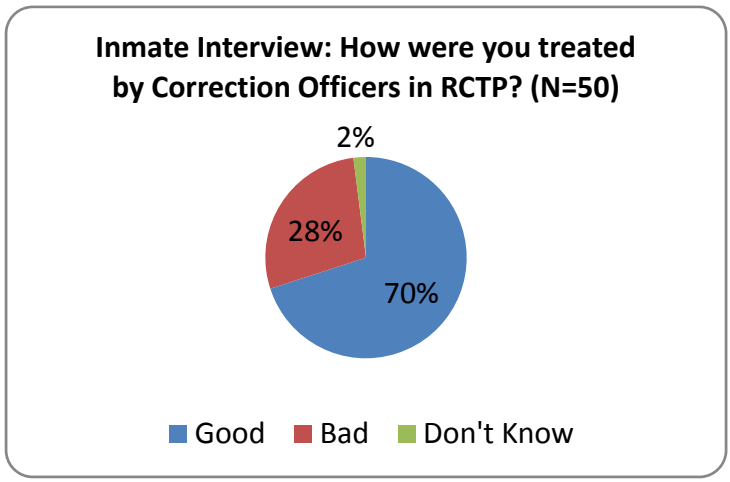
Opinions about mental health staff:

The majority of inmates reported they were able to speak with mental health staff privately outside of the observation cell or in a private office if they were in the dorm[22]. Female inmates said they were able to speak privately with mental health staff more often than male inmates.

However, only 39 percent of inmates responding to the survey believed that the mental health staff in the RCTP helped them, 49 percent thought that mental health staff did not help them and 12 percent did not know whether mental health staff helped them. More female inmates said that mental health staff helped them than male inmates did.

The majority of inmates interviewed thought that mental health staff treated them well; only five inmates complained of poor treatment by mental health staff.

Opinions about Correction Officers:



Inmates interviewed by Commission staff were asked how they were treated by DOCS staff while they were in the RCTP. This was an open-ended question and the responses were characterized as good and bad. The majority of inmates at each of the review facilities reported that they received good treatment from the corrections officers in the RCTP.

Comments that were categorized as "good" included: "treated me like an adult," "if you respect them, they respect you." Some inmates found their interactions with corrections officers to be very helpful; one inmate said a corrections officer taught him to meditate and it helped him calm down. Some inmates observed that corrections officers spend more time with them than mental health staff, so it was helpful when the corrections officers were respectful and took time to speak with the inmate.

Comments that were categorized as "bad" included: disrespectful, called people names, called medication "skittles," threatened inmates or tried to irritate inmates. Some alleged that corrections officers roughed them up, turned fans on them, threw cold water at them, shoved them or tampered with their food.

The survey sent to inmates did not specifically ask about treatment by corrections officers, but space was provided for inmates to write anything else they wanted the Commission to know. Thirteen inmates responding to the survey alleged that, while they were in the RCTP, corrections officers were verbally and/or physically abusive to them or other inmates. None of the women responding to the survey alleged physical or verbal abuse.

[22] 61 percent of inmates responding to the survey and 86 percent of inmates interviewed said they were able to speak privately with mental health staff.

Physical setting of RCTPs:
Inmates responding to the survey and those interviewed in all facilities complained that it was cold in the observation cells. Some inmates reported that corrections officers turned fans on inmates to get them to be quiet or for other punitive purposes. During one of the Commission's site visits, an inmate in the observation cell called Commission staff over and complained about being cold. Commission staff observed that the windows were open and the corrections officers working in the RCTP were wearing outdoor jackets while the inmate was wearing only the suicide prevention smock.

The majority of inmates reported that the observation cells and dormitory beds were clean and Commission staff found the units to be clean and freshly painted during site visits.

Amenities:
A specialized tear-resistant suicide prevention smock is one of the minimum items provided to inmates upon admission into an observation cell. Underwear and shirts and pants may be provided if OMH staff determine it is clinically appropriate. Many inmates participating in the survey and interview process complained about the smock, stating that it was very cold and some said it was degrading to leave the observation cell to see OMH staff wearing the smock and no underwear. Some inmates also complained about not having any eating utensils.

Case Review
The Commission's review of 59 inmates transferred to the RCTP validates the OMH staff assertion that RCTPs serve a diverse group of people, some in need of mental health intervention for psychiatric stabilization, some in need of respite from environmental stressors and some in pursuit of secondary gain which can be hard to ascertain. The progress notes reviewed by the Commission largely reflected that once inmates stated they no longer had thoughts of self-harm, were feeling better and were ready to leave and were observed to be medication compliant, they were transferred out of the RCTP. Often progress notes documented encouragement by OMH nursing and clinical staff to comply with medications and engage in alternative problem-solving behavior (e.g., journaling) and some staff sought to ensure that inmates knew how to contact mental health staff if needed.

Access to CNYPC:
OMH staff reported in surveys submitted to the Commission that there was timely transfer to CNYPC most of the time for inmates in need of inpatient care. There were six inmates included in the Commission's review that were transferred to CNYPC from RCTP during the study period. These transfers appeared appropriate and there did not appear to be any significant delays in transfer to CNYPC.

The Commission closely examined records of inmates who remained in observation cells for long periods of time and/or had multiple transfers to the RCTP to see whether transfer to CNYPC occurred or whether it may have been beneficial.

There were ten inmates included in the Commission's review who were in observation cells for more than seven days. CNYPC procedures require consultation with the regional psychiatrist at CNYPC for

inmates who are in the RCTP for seven calendar days[23]. Consultation with the regional psychiatrist at CNYPC was documented in progress notes for three inmates and two of those inmates were accepted for transfer to CNYPC. There was no documentation of consultation taking place for the other seven inmates. A second opinion may have been beneficial for some of those seven inmates.

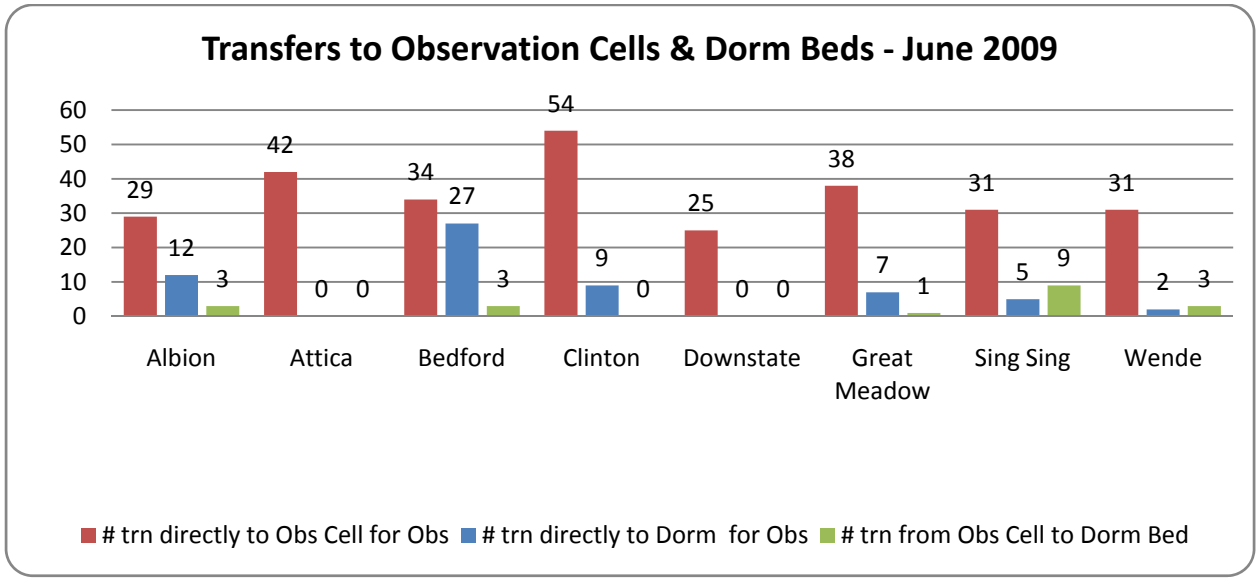
In addition, there were 16 inmates who had three or more transfers to the RCTP during the three month study period and one of those inmates was transferred to CNYPC. The Commission compared the inmates with multiple transfers who were not transferred to CNYPC with inmates who were transferred to CNYPC. It was difficult to determine, based upon the documentation provided, why two of these inmates were not transferred to CNYPC and the inmates they were compared to were transferred.

[23] CNYPC Corrections-Based Operations Manual. Chapter 4 – Crisis Intervention Services RCTP Observation Cells Policy #4.0, 6.a.

3. Dorm Bed Utilization

The CNYPC Procedures Manual states that dorm beds can be used to safely house inmates for the purpose of observing and monitoring behavior, and this type of housing should be used with least restrictive principle of treatment in mind[24]. The Commission found that dorm bed utilization varied by facility and could not find, based on the available data, a reason for this difference.

Utilization Data



Over three-quarters (284/365) of the transfers into the RCTP in June 2009 were to observation cells. Less than a quarter of inmates were either transferred directly to dorm beds or from an observation cell into a dorm bed. Only 19 inmates were transferred from an observation cell into a dorm bed in June 2009.

The utilization of dorm beds varied by facility; at Bedford about half of the inmates who were transferred to the RCTP went into dorm beds and at Attica there were no transfers into dorm beds. Downstate does not have any dorm beds.

The Commission discussed this variation in utilization with DOCS and OMH. DOCS provided the Commission with RCTP utilization statistics for all RCTPs for 2009[25]. This data shows a similar variation in utilization patterns.

Security Issues:
One explanation suggested by DOCS for this variation was that it could be due to the security needs of the inmates. However, the 2009 utilization data shows a wide variation of dorm bed utilization among maximum security facilities; the average occupancy rate for dorm beds ranged from 1.7 percent at Attica to 97.7 percent at Elmira.

[24] CNYPC Corrections-Based Operations Manual. Chapter 4 – Crisis Intervention Services #4.2 RCTP Dorm.
[25] See Appendix 4.

In addition, many inmates (25 percent in June) were transferred from other facilities, including minimum and medium security facilities and CNYPC. Only one inmate who was transferred from a minimum facility was transferred directly into a dorm bed in June 2009.

Transfers from CNYPC:

The CNYPC Operations Manual indicates that, when an inmate is discharged from CNYPC, the unit chief or nurse administrator works with the watch commander to ensure the inmate is assessed by an OMH clinician upon arrival at the facility to determine whether it is appropriate for the inmate to be placed in his/her designated housing unit or transferred to an RCTP bed for further evaluation[26]. The policy does not specify whether or not the inmate should be placed in an observation cell or a dorm bed.

In June 2009, 16 inmates were transferred from CNYPC to the RCTPs at seven of the eight correctional facilities included in the Commission's review. Only two facilities placed inmates returning from CNYPC into a dorm bed upon their transfer to the RCTP. All 16 inmates were transferred to general population or Intermediate Care Program (ICP) or another special housing program when they were discharged from the RCTP.

The Commission's review included seven inmates who were transferred into the RCTP upon return from CNYPC. Four of the inmates were transferred into a dorm bed. The other inmates were transferred into observation cells. The Commission did not find significant differences in the descriptions of presenting symptoms and adjustment to the return to the correctional facility from CNYPC among the inmates placed in a dorm bed and those placed in an observation cell.

[26] CNYPC Corrections-Based Operations Manual, Discharges from Inpatient Services, Policy #7.5.

4. Documentation

Thorough, accurate documentation increases the likelihood that people receive consistent and informed care and decreases the potential for miscommunication and errors. Documentation should describe the care provided and be used to communicate observations, decisions, actions and outcomes. Thorough, accurate documentation about the mental health care inmates receive is critical given the movement of inmates between correctional facilities. During the month of June, almost 25 percent of the transfers into RCTPs at the eight facilities in the Commission's review came from and went back to a different correctional facility or CNYPC.

CNYPC's Corrections-Based Operations Manual requires the following documentation when an inmate is transferred to an observation cell or a dorm bed in the RCTP[27]:

- Nursing assessment;
- RCTP monitoring chart (observation cells only); and
- Progress notes.

In addition, DOCS maintains security log books for all inmates in the RCTP as well as suicide watch log books for inmates on a suicide watch.

The Commission reviewed three months of documentation for the 59 inmates included in this review. These inmates generated 120 transfers to the RCTP during the three-month time period. For the most part, facilities used the forms prescribed by CNYPC[28], but the quality of documentation varied by facility. The majority of the daily observation notes and psychiatric notes reviewed were thorough and often documented involvement of the inmate in discussions about mental health care. However, many of the nursing assessments, progress notes and RCTP monitoring charts were incomplete. In addition, there appears to be a failure to document consultation with CNYPC for inmates who remain in observation cells for seven days or more.

A discussion of the Commission's findings regarding documentation follows below.

A. Nursing Assessment

All patients transferred into a dormitory bed or observation cell in the RCTP are supposed to have a nursing assessment completed within 24 hours of transfer to RCTP[29]. CNYPC policy states that "This assessment recognizes the immediate psychiatric nursing needs of the individual requiring crisis intervention and transfer for observation and treatment."

The nursing assessment form documents the reason for transfer, presenting symptoms, medical conditions, medications and vital signs. During the assessment, the nurse conducts a risk assessment

[27] CNYPC Corrections-Based Operations Manual. Chapter 4 – Crisis Intervention Services, #4.0, 3.a. Examples of complete and incomplete documentation are in Appendix 5.
[28] CNYPC has made what appear to be minor changes to the forms used to document care received in the RCTP. Some facilities used older versions of forms, some appeared to have re-created the CNYPC forms for use in their facility but the information required to be recorded was the same in all instances.
[29] CNYPC Corrections-Based Operations Manual, policy#9.18 (4/3/09)

which includes a suicide risk assessment, checks the inmate's nutritional/hydration status and performs a psychosocial assessment. These results are documented on the assessment form along with a summary of findings, recommended nursing interventions and a plan of care. Nurses must document the reason for not completing any of the required assessment areas.

There were only four totally completed nursing assessment forms out of 120 RCTP transfers reviewed[30]. The most frequent omissions on the nursing assessment forms reviewed were:

- Risk Assessments. Many forms had incomplete suicide assessments (25 inmates/35 transfers).
- Vital Signs. Vital signs were incomplete or missing without any reason given for not taking them for 23 inmates and 30 transfers. All facilities had elements missing in this section. In addition, when a reason was given for not obtaining vital signs, the most frequent reason given was "patient in cell."
- Nutritional/Hydration Assessment & Triggers. This section was blank or incomplete for 32 inmates and 50 transfers. Only one facility had this section completed for every inmate.
- Psychosocial Assessments. The most frequent omission was the description of impaired judgment when the assessment identified the inmate's judgment as impaired. This was not described for 35 inmates and 57 transfers.

B. RCTP Monitoring Forms

The RCTP monitoring form documents the watch status and the amenities permitted in the observation cell (i.e., blankets, mats, toiletries) for inmates transferred into an observation cell. This form is posted at the cell for clear reference by DOCS and OMH staff and then filed in the inmate's record.

No facility had RCTP monitoring forms completely filled out for every inmate on every transfer. The sections of the forms that were most frequently incomplete were:

- Type of Observation. This section documents whether or not an inmate in an observation cell is on a suicide watch and when the watch began and ended. In some cases, the entire area was blank; in others, the times a watch ended were blank. All facilities except for one had incomplete observation sections.
- Amenities. Inmates in observation cells are permitted a limited number of amenities (mats, footwear, etc.) in their cell. Individualized clinical reasons for non-approval or removal of any of the cell items are supposed to be documented on the form and initialed by RCTP mental health staff. In some instances, there was no documentation of the reason for amenities being taken away or any dates or initials for amenities given.

In addition, there were some conflicts noted between documentation included in the RCTP monitoring form and other documents and/or the inmate's report of treatment received in the RCTP. One inmate told Commission staff that he never received eating utensils but his RCTP monitoring sheet said he did get utensils. One inmate had his amenities removed late in his stay in the observation cell even though

[30] The Commission did not receive nursing assessments for 16 transfers. The missing records may exist but perhaps were not copied and/or given to Commission staff during the on-site review.

clinical notes did not indicate he was suicidal and one inmate's chronological record dates did not match dates on RCTP monitoring form.

The RCTP monitoring sheet for nine transfers, almost six percent of the total reviewed, did not have the reason for transfer entered on the RCTP monitoring sheet.

Finally, the Commission strongly recommends that OMH reconsider their recent decision to only identify the reason for transfer to the observation cell if an inmate harmed themselves, threatened to harm themselves or recently became assaultive. As stated previously, many inmates are transferred to observation cells for other mental health reasons, including psychiatric decompensation, and staff on each shift need to know why an inmate was transferred so they can appropriately monitor and evaluate the inmate's condition.

C. Progress Notes

- **Nursing Progress Notes**

  A nursing progress note is to be completed every shift for all patients transferred into the observation cells and dormitory beds in the RCTP[31]. The progress note documents the nurse's assessment of each inmate's current psychiatric condition and includes an ongoing assessment of the patient's hydration status. Progress notes are not required once the patient no longer requires the services of the RCTP and is awaiting movement to a different housing location.

  There were only two facilities that had no nursing progress notes missing in the files obtained by Commission staff[32]. At three facilities it appeared that nursing progress notes were often not completed on the day that the inmate was transferred out of the RCTP. One inmate had nine days of notes missing.

  The most frequent omissions from nursing progress notes were:

  1. Location where observation occurred. All facilities had some progress notes that did not note if the observation was occurring in an observation cell or dorm bed. This information was missing for multiple days at five facilities[33].

  2. Medical medication compliance. There was only one facility that had this section completed for all inmates. This section was often blank, even in instances when the nursing assessment listed medical medications for inmates. All of the inmates at three facilities had this documentation missing, many on multiple shifts and days.

[31] CNYPC Corrections-Based Operations Manual, policy #4.6 (7/09). Nursing progress notes are also required for inmates awaiting transfer into the RCTP, or would be in the RCTP except for circumstances preventing the transfer (i.e., inmates who need a Medical, 1:1 observation).
[32] Missing records may exist but perhaps were not copied and/or given to Commission staff during the on-site review.
[33] Some facilities simply entered "RCTP" for housing location.

3. Comment section. The quality and level of detail varied in the comment section at the end of each progress note. Some were detailed, some provided minimal information (e.g., just "no c/o"). Nurses at one facility entered combined "Day/Eve" notes and there was variation within facilities about entering the time of the observation and/or the shift during which the observation occurred[34].

- **RCTP Observation Daily Progress Note**

  According to CNYPC procedures, the primary therapist, or RCTP coordinator, must complete a daily observation progress note every business day while an inmate is in an observation cell and weekly for inmates in dorm beds[35]. Overall, there were many instances of detailed notes and very few problems with documentation in this area. However, the Commission found documentation deficiencies for inmates who remained in observation cells for more than seven calendar days.

  Length of Stay Seven Calendar Days: The CNYPC manual states that if an inmate remains in an observation cell for seven calendar days, there must be a consultation with the regional psychiatrist at CNYPC and this consultation must be documented in the progress note[36]. This consultation must occur regardless of any other previous consultations and even if the inmate no longer requires RCTP care but is awaiting DOCS transfer. There were ten inmates in the Commission's review sample who were in the RCTP for more than seven days. There was documentation of consultation with the regional psychiatrist at CNYPC for three inmates and two of those inmates were accepted for transfer to CNYPC. There was no documentation of consultation with the CNYPC regional psychiatrist for seven inmates.

- **Psychiatric Progress Note**

  Psychiatric progress notes are to be completed upon transfer to, and discharge from, RCTPs and weekly if the patient remains in RCTP[37]. Overall, psychiatric progress notes were complete and legible. However, psychiatric progress notes at one facility did not conform to the form prescribed by the CNYPC manual. The psychiatric progress notes at this facility were checklists and many notes were illegible[38].

- **DOCS Log Books**

  The DOCS log books reviewed varied by facility in the level of detail provided. Some log books, on some shifts, noted the times that mental health staff entered and left the unit, others did not. Log books for one-to-one watches appeared thorough. However, OMH policies state that each time an OMH clinician evaluates an inmate on a suicide watch the clinician will review the

[34] There appears to be a conflict between the nursing progress note forms that say notes must identify shift and the procedures that say the nurse must document the time.
[35] CNYPC Corrections-Based Operations Manual, Policy #4.0 RCTP Observation Cells and #4.1 Dorm beds
[36] CNYPC Corrections-Based Operations Manual, Policy #4.0.

[37] CNYPC Corrections-Based Operations Manual, #9.27.
[38] See Appendix 5 for an example.

entries in the Suicide Watch log and sign the log book. The Commission was unable to determine whether this occurred. Suicide log books did have signatures but it could not be determined if the signatures were from DOCS or OMH staff and no mental health progress notes referenced a review of the content in the DOCS log books.

- **Watches**

  DOCS and OMH policies and procedures identify and define the procedures to be followed for the different types of watches that can take place in the RCTP and these are noted on the RCTP monitoring form. OMH policies define suicide and special watches, and DOCS policies identify two different types of suicide watches: one-on-one and one-on-multiple watches. In addition, RCTPs appear to use different terms – some monitoring forms or nursing assessments noted that the inmate was on a "close watch" or a "five minute" watch but there were no policies defining what those watches were. Security log books only documented one- on-one suicide watches.

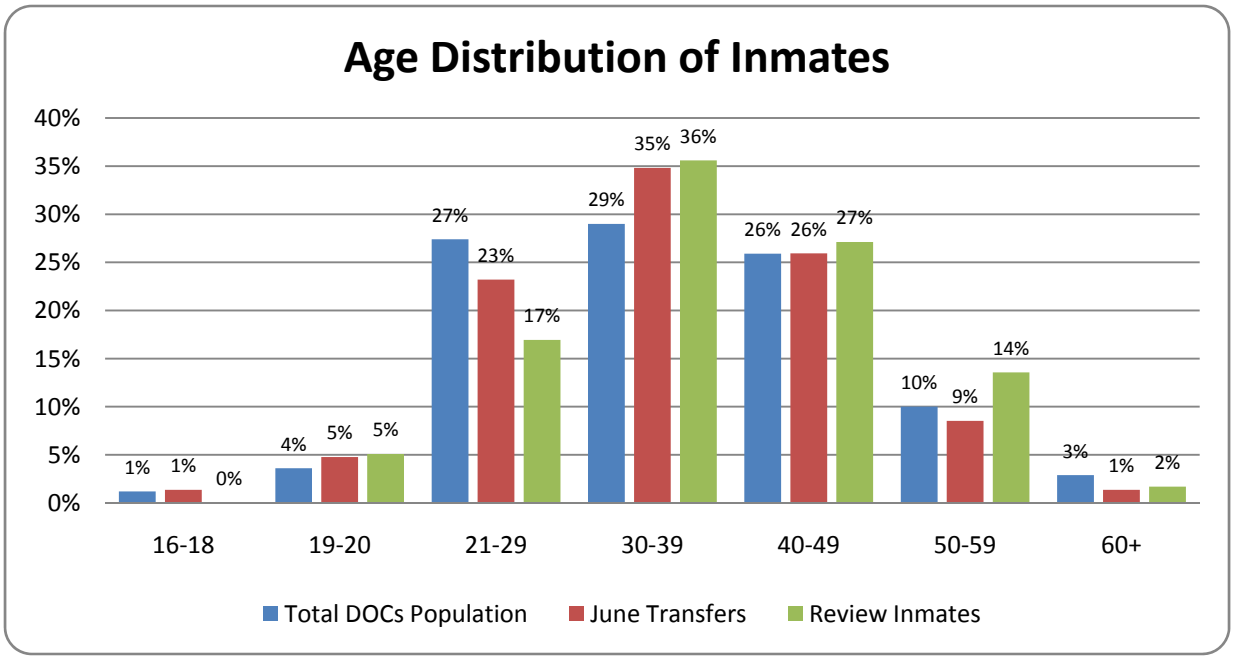
  During several of the Commission's RCTP exit interviews, DOCS and OMH central office staff stated that these discrepancies have been addressed. The most recent revision to the RCTP monitoring chart (8/09) identifies three different types of watches: one-to-one Suicide Watch, one-to-two Suicide Watch and Special Watch, and these are defined in the policies and procedures manual. In addition, DOCS provided the Commission with a new draft directive dated April 30, 2010 that addresses these discrepancies as well.

Appendices:

1. Demographic Information.
2. Definition of “S” Designation in SHU Exclusion Law.
3. Alcoholism and Substance Abuse Available to the Mentally Ill in DOCS.
4. 2009 Dorm Bed Utilization Data Compiled by DOCS
5. Examples of Documentation

Appendix 1: Demographic Information

Sex	% or All Inmates (Jan 09 N=60,000)	% of inmates transferred in June 2009 (N=293)	% of CQC Review Inmates (N=59)
Male	96%	75%	73%
Female	4%	25%	27%



This chart compares the percent of inmates by age group for all DOCS inmates, (n=60,000), inmates transferred to the RCTP in June (N=293) and the inmates included in the CQCAPD review (n=59). The ages of inmates transferred into the RCTP in June 2009 ranged from 17 to age 63.

Race/Ethnicity	% or All Inmates (Jan 09 N=60,000)	% of inmates transferred in June 2009 (N=293)	% of CQC Review Inmates (N=59)
White	21.3%	26.6%	32.2%
African-American	51.5%	48.1%	49.2%
Hispanic	25.2%	22.9%	18.6%
Asian	0.5%	0.7%	0.0%
Native American	0.7%	0.0%	0.0%
Other	0.5%	1.4%	0.0%
Unknown	0.3%	0.3%	0.0%

Appendix 2
SHU Exclusion Law
Definition of Serious Mental Illness

An inmate has a serious mental illness when he or she has been determined by a mental health clinician to meet at least one of the following criteria:

1. He or she has a current diagnosis of, or is diagnosed at the initial or any subsequent assessment conducted during the inmate's segregated confinement with, one or more of the following types of Axis I diagnoses, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and such diagnoses shall be made based upon all relevant clinical factors, including but not limited to systems related to such diagnoses:
    a. Schizophrenia (all sub-types),
    b. Delusional disorder,
    c. Schizophreniform disorder,
    d. Schizoaffective disorder,
    e. Brief psychotic disorder,
    f. Substance-induced psychotic disorder (excluding intoxication and withdrawal),
    g. Psychotic disorder not otherwise specified,
    h. Major depressive disorders, or
    i. Bipolar disorder I and II;
2. He or she is actively suicidal or has engaged in a recent, serious suicide attempt;
3. He or she has been diagnosed with a mental condition that is frequently characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health;
4. He or she has been diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on life or on mental or physical health;
5. He or she has been diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in a significant functional impairment involving acts of self-harm or other behavior that have a seriously adverse effect on list or on mental or physical health; or
6. He or she has been determined by a mental health clinician to have otherwise substantially deteriorated mentally or emotionally while confined in segregated confinement and is experiencing significant functional impairment indicating a diagnosis of serious mental illness and involving acts of self-harm or other behavior that have a serious adverse effect on life or on mental or physical health.

Appendix 3

Alcohol and Substance Abuse Services Available to the Mentally Ill in DOCS

Integrated Dual Disorders Treatment

Integrated Dual Disorders Treatment (IDDT) is a program that is offered within the NYS Department of Corrections. This program is designed to provide integrated treatment to support recovery from co-occurring mental illness and substance use disorders. IDDT is offered to inmates in Intermediate Care Programs (ICP), Behavioral Health Units (BHU) and the Residential Mental Health Unit (RMHU). It is co-facilitated by the Department of Corrections substance abuse staff and the Office of Mental Health clinical staff assigned these programs. Successful completion of the program requires minimum 9 months participation.

Alcohol and Substance Abuse Treatment for the Mentally Ill

Alcohol and Substance Abuse Treatment (ASAT) for the Mentally Ill is a program that is offered within the NYS Department of Corrections. It is offered at Mid State Correctional Facility for males and at Bedford Hills Correctional Facility for females. This program is residential and designed to assist inmates who are active on the OMH caseload with co-occurring mental illness and substance use disorders. The program is facilitated by DOCS substance abuse staff and involves a variety of treatment approaches to initiate recovery from mental illness and substance use disorders. Education, individual and group counseling and relapse prevention specific to both disorders are offered.

Alcohol and Substance Abuse Treatment

Alcohol and Substance Abuse Treatment (ASAT) is a program that is offered within the NYS Department of Corrections. This program is designed to assist inmates with substance use disorders in beginning the process of recovery from alcohol and/or other addictive substances. A variety of approaches are used to include education, individual and group counseling and relapse prevention. The ASAT program is offered in four settings: residential, modular, Shock Incarceration and Willard Drug Treatment Campus. It is offered to any general population inmate, to include those on the active mental health caseload, with an identified program need for substance abuse treatment. Successful completion of the program requires minimum 6 months participation.

Appendix 4
DOCS Satellite Unit Bed Utilization 2009

Satellite Units	Average			Average		
	Capacity (Beds) DORM	Occupancy (Inmates) DORM	Utilization % (Inmates/Beds) DORM	Capacity (Beds) CELL	Occupancy (Inmates) CELL	Utilization % (Inmates/Beds) CELL
ALBION	9.0	1.1	12.2%	6.0	2.2	36.2%
ATTICA	10.0	0.2	1.7%	10.0	5.9	58.7%
AUBURN	4.5	1.4	30.8%	5.0	3.9	78.2%
BEDFORD	9.0	2.9	31.9%	6.0	3.6	59.7%
CLINTON	4.0	1.3	33.5%	12.0	7.0	58.3%
DOWNSTATE	0.0	0.0	0.0%	12.0	6.3	52.5%
ELMIRA	4.9	4.8	97.7%	3.9	3.6	92.8%
FISHKILL	6.0	2.3	37.7%	6.0	1.8	30.8%
FIVE POINTS	10.0	0.6	6.0%	6.0	3.6	60.1%
GREAT MEADOW	8.0	1.8	21.9%	6.0	3.8	62.6%
GREEN HAVEN	6.5	4.8	74.1%	6.0	2.8	47.2%
MID-STATE	6.0	1.8	29.2%	6.0	2.3	37.7%
SING SING	16.0	6.1	38.0%	6.0	4.2	70.4%
SULLIVAN	4.0	0.3	7.5%	8.0	2.8	35.4%
WENDE	8.0	0.7	9.2%	6.0	3.2	53.5%
TOTAL	105.9	29.9	28.3%	104.9	57.1	54.4%

(prepared by DSB, 4/30/2010)

Appendix 5: Documentation Examples

1. Nursing Assessments

2. RCTP Monitoring Forms

3. Nursing Progress Notes

4. Psychiatric Progress Notes

330 MED CNYPC (REV. 9/08)

RCTP NURSING ASSESSMENT

Name: [redacted] DOB: [redacted]

C#: [redacted] DIN: [redacted]

Satellite Unit: [redacted] Date: 5/27/09

Sending Facility:

- < Required within 24 hours of transfer to RCTP
- < Update required within 7 days of re-transfer to RCTP.
- < Must be completed prior to admission to CNYPC when direct admission to CNYPC from RCTP.

SECTION A: ASSESSMENT

Date/Time of Transfer: 5/27/09 1:37 Housing location: Dorm #2

Reason for transfer/events occurring prior to transfer (may quote patient):

Presenting Symptoms: Pt tearfull, anxious + having racing thoughts as a result [redacted] is having difficulty adjusting in G.P. Pt placed in the Dorm at the request of [redacted] the request.

Medication Compliance: Psychiatric medications: ☒Y ☐N ☐Unknown Comment:

Medical medications: ☐Y ☒N ☐Unknown Comment:

List Medical Medications: None

Co-existing Medical Conditions: None

Allergies (adverse reactions) - medications, food, drugs: ☒Y ☐N ☐Unknown

Describe: Codiene

DOCS Medical notified of patient=s transfer: Time: 2:45 PM Person: [redacted] RN2

ALERT/RISK ASSESSMENT:

History of fire setting/property damage:	☐Y	☒N	History sexually aggressive behavior:	☐Y	☒N
History of physical/sexual abuse:	☐Y	☒N	History of seizures:	☐Y	☒N
* If yes: ☐Predator ☐Victim					
Dangerous to self:	☐Y	☒N	Dangerous to others:	☐Y	☒N
History of hoarding/cheeking medications:	☐Y	☒N	History of self-mutilation:	☐Y	☒N

Comments:

SUICIDAL IDEATION: ☐Y ☒N SUICIDE PLAN: ☐Y ☒N

Describe plan:

History of Suicide Attempts (describe): None

☐ Unknown History of Suicide Attempts

HOMICIDAL IDEATION: ☐Y ☒N Who:

VITAL SIGNS:

B/P 112/79 Pulse 95 Resp 16 Temp 99 Height 5'4" Weight

If not obtained, state reason:

HYGIENE: ☐Poor ☒Fair ☐Good Comment:

SLEEP DISTURBANCES: ☒Y ☐N ☐Unknown

Comment:

PAGE 1

NURSING ASSESSMENT: Name [redacted] C# [redacted] Date: [redacted]

NUTRITIONAL/HYDRATION ASSESSMENT and TRIGGERS (Check all reported by patient or others or none reported):
☐ Has refused & consecutive meals ☐ Documented weight change > 10 lbs. in 30 days ☐Insulin Dependent DM
☐ Difficulty chewing or swallowing ☐ Hx choking incident ☐MAO inhibitor/INH ☐ FBS >250mg or < 55 mg
☐ Life threatening allergy/sensitivity ☐ Diagnosis of pregnancy/lactation ☐ jaundice ☑ None reported

Lips: ☑ Moist ☐ Dry Tongue: ☐ Moist ☐ Dry, coated Skin: ☑ smooth ☐ Dry/scaling ☐ Atenting

DOCS Medical Department notified of Nutritional/Hydration triggers? ☐ Y ☐ N ☑ N/A

PAIN ASSESSMENT TRIGGERS:
Does patient report physical pain at this time? ☐ Y ☑ N
Has the patient had physical pain in the last 2 months? ☐ Y ☑ N Was it treated? ☐ Y ☐ N
Is patient receiving routine pain medication order? ☐ Y ☑ N
Are there [redacted]servable signs of physical pain? ☐ Y ☑ N
If YES, describe:

If Pain Scale used, score: Ø (1 - 5) If WONG scale used: Ø (1-5)
If YES, was patient referred to DOCS Medical Department? ☐ Y ☐ N ☑ N/A

SECTION B: PSYCHOSOCIAL (check all boxes that apply and describe if necessary):

ORIENTATION:
Time: ☑ Y ☐ N Place: ☑ Y ☐ N Person: ☑ Y ☐ N ☐ Patient uncooperative

ACTIVITY PROCESS:
☑ cooperative ☐ uncooperative ☐ calm ☐ restless ☐ coherent ☐ incoherent
☐ agitated ☐ threatening ☐ aggressive ☐ assaultive ☐ withdrawn
Describe:

INTERPERSONAL PROCESS:
Altered non-verbal communication:
☑ no alteration noted ☐ exaggerated or bizarre gestures or movements ☐ posturing
☐ intrusive ☐ aversion to contact with others ☐ lack of eye contact

Disturbance of speech:
☑ no disturbance noted ☐ mute ☐ repetitive ☐ stuttering ☐ slurred
☐ rapid ☐ pressured ☐ slowed ☐ loose associations
Describe:

SENSORY PERCEPTION PROCESS:
☐ no deficit noted ☐ paranoid ideation ☐ delusional ☐ suspicious
Describe:

Hallucinations: ☑ Denies
☐ Present: ☐ auditory ☐ visual ☐ tactile ☐ olfactory
Content of hallucinations:

EMOTIONAL PROCESS:
☑ appropriate affect ☐ inappropriate affect ☐ flat affect ☐ labile ☐ euphoric
☐ fearful ☐ tearful ☐ angry ☐ sad ☐ anxious
Describe:

PAGE 2

NURSING ASSESSMENT: Name: [redacted] C#: [redacted] Date: [redacted]

COGNITIVE PROCESS:
☒ no deficit noted ☐ knowledge deficit ☐ preoccupied ☐ obsessions ☐ history of head injury

Memory: Recent: ☒ Good ☐ Impaired
Remote: ☒ Good ☐ Impaired
Immediate: ☒ Good ☐ Impaired

Insight:
Recognizes need for help: ☒ Y ☐ N
Desires help or treatment: ☒ Y ☐ N

Judgment: ☐ Good ☒ Impaired
Describe: Inability to cope & sch w/ or GP, transfer level "feels frightened, nervous"

SECTION C: SUMMARY OF FINDINGS (from Sections A and B)

STRENGTHS (Physical & Psychiatric): Denies SI, AVH hallucinations, Able to identify areas of concern ie Chang in medications. Good physical health

WEAKNESSES (Physical & Psychiatric):
Inability to sleep in 4 days
3 admissions to RCTP in 6 months

NURSING DIAGNOSIS(ES) *Review this Nursing Assessment to develop final Nursing Diagnosis(es):*

a.
Diagnoses: Inability to cope
Related to: incarceration
As evidenced by: c/o feeling anxious & frightened
b.
Diagnoses: Disturbed sleep pattern
Related to: Possibly related to medication change
As evidenced by: c/o not sleeping in 4 days

SUMMARY OF OVERALL ASSESSMENT FINDINGS AND RECOMMENDED NURSING INTERVENTIONS/PLAN OF CARE
Summarize overall findings and develop Interventions based on nursing diagnosis:
Pt c/o feeling anxious & frightened & having racing thoughts, as a result pt is having difficulty adjusting in GP & placed in OBSO for monitoring.

R.N. SIGNATURE: [redacted] RN DATE: 5/2/09

6/1/09 Pt admitted to admin c c/o SI crying, nervous, panicky, fearful, c/o AVH/e hallucinations see progress note.

UPDATE:

R.N. SIGNATURE: [redacted] RN DATE: 6/1/09

UPDATE:

R.N. SIGNATURE: DATE:

330 MED CNYPC (REV. 11/15/04)

RCTP NURSING ASSESSMENT

Name: [redacted] DOB: [redacted]

C#: [redacted] DIN: [redacted]

Satellite Unit: [redacted] Date: 6/3/05

Sending Facility: [redacted]

- **Required within 24 hours of transfer to RCTP**
- **Update required within 7 days of re-transfer to RCTP.**
- **Must be completed prior to admission to CNYPC when direct admission to CNYPC from RCTP.**

SECTION A: ASSESSMENT

Date/Time of Transfer: 6/3/04 5:30 PM Housing location: BHU - SW Hosp on a 1, 1

Reason for transfer/events occurring prior to transfer (may quote patient):

Presenting Symptoms:

Medication Compliance: Psychiatric medications: ☐ Y ☐ N ☐ Unknown

Medical medications: ☐ Y ☐ N ☐ Unknown

List Medical Medications: Denies

Co-existing Medical Conditions: Denies

Allergies (adverse reactions) - medications, food, drugs: ☐ Y ☒ N ☐ Unknown

Describe:

DOCS Medical notified of patient's transfer: Time: Person:

NOTE: THIS REPORT IS STRICTLY CONFIDENTIAL AND IS FOR THE INFORMATION ONLY OF THE PERSON TO WHOM IT IS ADDRESSED. NO RESPONSIBILITY CAN BE ACCEPTED BY CENTRAL NEW YORK PSYCHIATRIC CENTER IF IT IS MADE AVAILABLE TO ANY OTHER PERSON, INCLUDING THE PATIENT. DESTRUCTION OF THIS MATERIAL IS REQUIRED AFTER STATED USE

ALERT/RISK ASSESSMENT:

History of fire setting/property damage:	☐ Y ☒ N	History sexually aggressive behavior:	☐ Y ☒ N
History of physical/sexual abuse:	* ☒ Y ☐ N	History of seizures:	☐ Y ☒ N
* If yes: ☐ Predator ☒ Victim			
Dangerous to self:	☒ Y ☐ N	Dangerous to others:	☐ Y ☒ N
History of hoarding/cheeking medications:	☐ Y ☒ N	History of self-mutilation:	☐ Y ☒ N

Comments:

SUICIDAL IDEATION: ☒ Y ☐ N **SUICIDE PLAN:** ☒ Y ☐ N

Describe plan:

History of Suicide Attempts (describe):

☐ Unknown History of Suicide Attempts

HOMICIDAL IDEATION: ☐ Y ☒ N Who:

VITAL SIGNS:

B/P 139/84 Pulse 80 Resp. 24 Temp 98.7 Height 5'11" Weight

If not obtained, state reason:

HYGIENE: ☐ Poor ☐ Fair ☐ Good Comment:

SLEEP DISTURBANCES: ☐ Y ☐ N ☐ Unknown

Comment: 2 days & short

PAGE 1

NURSING ASSESSMENT: Name [redacted] C# [redacted] Date: 6/3/05

NUTRITIONAL/HYDRATION ASSESSMENT and TRIGGERS (Check all reported by patient or others):
☐ Has refused _____ consecutive meals ☐ Documented weight change > 10 lbs. In 30 days ☐Insulin Dependent DM
☐ Difficulty chewing or swallowing ☐ Hx choking incident ☐MAO inhibitor/INH ☐ FBS >250mg or < 55 mg
☐ Life threatening allergy/sensitivity ☐ Diagnosis of pregnancy/lactation ☐ jaundice ☐ **None reported**
Lips: ☑ Moist ☐ Dry **Tongue:** ☐ Moist ☐ Dry, "coated" **Skin:** ☑ smooth ☐ Dry/scaling ☐ "tenting"
DOCS Medical Department notified of Nutritional/Hydration triggers? ☐ Y ☐ N ☑ N/A

PAIN ASSESSMENT TRIGGERS:
Does patient report physical pain at this time? ☐ Y ☑ N
Has the patient had physical pain in the last 2 months? ☐ Y ☑ N Was it treated? ☐ Y ☐ N
Is patient receiving routine pain medication order? ☐ Y ☑ N
Are there any observable signs of physical pain? ☐ Y ☑ N
If **YES,** describe:

If Pain Scale used, score: N/A (1 - 5) If WONG scale used: _____ (1-5)
If YES, was patient referred to DOCS Medical Department? ☐ Y ☐ N ☐ N/A

***SECTION B: PSYCHOSOCIAL* (check all boxes that apply and describe if necessary):**

ORIENTATION:
Time: ☑ Y ☐ N Place: ☑ Y ☐ N Person: ☑ Y ☐ N ☐ Patient uncooperative

ACTIVITY PROCESS:
☐ cooperative ☐ uncooperative ☐ calm ☐ restless ☐ coherent ☐ incoherent
☐ agitated ☐ threatening ☐ aggressive ☐ assaultive ☑ withdrawn ☑ tearful
Describe:

INTERPERSONAL PROCESS:
Altered non-verbal communication:
☑ no alteration noted ☐ exaggerated or bizarre gestures or movements ☐ posturing
☐ intrusive ☐ aversion to contact with others ☐ lack of eye contact

Disturbance of speech:
☐ no disturbance noted ☐ mute ☐ repetitive ☐ stuttering ☐ slurred
☐ rapid ☐ pressured ☐ slowed ☐ loose associations
Describe: Low

SENSORY PERCEPTION PROCESS:
☐ no deficit noted ☐ paranoid ideation ☐ delusional ☐ suspicious
Describe:

Hallucinations: ☑ Denies
☐ Present: ☐ auditory ☐ visual ☐ tactile ☐ olfactory
Content of hallucinations:

EMOTIONAL PROCESS:
☐ appropriate affect ☐ inappropriate affect ☐ flat affect ☐ labile ☐ euphoric
☐ fearful ☐ tearful ☐ angry ☐ sad ☐ anxious
Describe:

PAGE 2

NURSING ASSESSMENT: N[redacted] C#[redacted] Date: 6/3/09

COGNITIVE PROCESS:
☐ no deficit noted ☐ knowledge deficit ☐ preoccupied ☐ obsessions ☐ history of head injury

Memory:	Recent:	☑ Good	☐ Impaired
	Remote:	☑ Good	☐ Impaired
	Immediate:	☑ Good	☐ Impaired

Insight:
Recognizes need for help: ☐ Y ☑ N
Desires help or treatment: ☐ Y ☑ N

Judgment: ☐ Good ☑ Impaired
Describe:

***SECTION C: SUMMARY OF FINDINGS* (from Sections A and B)**

STRENGTHS (Physical & Psychiatric):
Young
Good Health

WEAKNESSES (Physical & Psychiatric):
Impulsive
Mental Health history

NURSING DIAGNOSIS(ES) - *Review this Nursing Assessment to develop final Nursing Diagnosis(es):*
a.
Diagnoses: Poor Coping
Related to: Impulsivity
As evidenced by: hosp. ups + SI + a Plan
b.
Diagnoses:
Related to: _____ As evidenced by:

SUMMARY OF OVERALL ASSESSMENT FINDINGS AND RECOMMENDED NURSING INTERVENTIONS/PLAN OF CARE *Summarize overall findings and develop Interventions based on nursing diagnosis:*
1. To be evaluated by MD Psy + meds
2. Treatment team to evaluate + Treat.
3. Clinician to help pt [redacted] family stressors.

R.N. SIGNATURE [redacted] DATE: 6/3/09

UPDATE: _____

R.N. SIGNATURE _____ DATE: _____

UPDATE: _____

R.N. SIGNATURE: _____ DATE: _____

MED CNY 455 (8/09) | Central New York Psychiatric Center | OMH-PHI

RCTP Monitoring Chart

Patient Name:	DIN #:	C #:	Unit:
[redacted]	[redacted]	[redacted]	[redacted]

Date & Time of Transfer to Cell:	Transfer to observation cell from: (GP, SHU, ICP, TRICP, BHU, 4301 etc.)	Transfer initiated by:
9/25/09 2A	E2 - 16	[redacted]

Reason for Transfer to cell: ☐ Threat of Self-Harm ☐ Assaultive
Overdose ☑ Self-Injurious Behavior ☐ Other Mental Health Reason

Type of Observation (select only one)	Started: Mo/Day Time	Ended: Mo/Day Time	Signature:
1:1 Suicide Watch	09/25 2:00 (am) pm	09/28 11:00 (am) pm	[redacted]
1:2 Suicide Watch	___/___ ___:___ am pm	___/___ ___:___ am pm	
Special Watch (only for 3 or more non-suicidal inmate-patient who do not require constant observation)	___/___ ___:___ am pm	___/___ ___:___ am pm	
Regular 15 min. rounds	09/28 11:00 (am) pm	09/29 11:00 (am) pm	[redacted]

Patient must be provided with the following minimum observation cell items as listed below. If any item is not provided, the clinical rationale must be documented below under "reason for non-approval or removal."

Minimum Cell Items	Date Given/ Initials	Date Removed/ Initials	Date Given/ Initials	Date Removed/ Initials	Reason for non-approved or removal
Specialized tear and fire resistant mattress	9/25 -				
Two specialized tear resistant safety mats	9/25 -				
One specialized tear resistant smock	9/25 -				
Feminine Hygiene items if needed	9/28 MD				Suicidal Education
Footwear	9/25 -				
Soap (Returned following use) /wash cloth	9/28 MD				Suicidal Education
Toothbrush (Returned following use)	9/28 MD				Suicidal Education
Toothpaste (Returned following use)	9/28 MD				Suicidal Education
Eating Utensils (Returned following use)	9/28 MD				Suicidal Education

Based on clinical determination indicate those additional amenities provided with date.

Additional Items	Date Given/ Initials	Date Removed/ Initials	Date Given/ Initials	Date Removed/ Initials	Reason for Removal or Justification for "Other"
Extra Mat					
Reading Material (without staples)					
Pen (bendable)					
Writing Paper					
Pajamas	9/28 MD				
Underwear /Panties/Bra	9/28 MD				
Shirts/Pants (Greens)					
Socks /Slippers	9/28 MD				
Blanket					
Other: Include Justification					

Date/Time Transferred out of RCTP Cell: 9/29/09 Signature/ Title: [redacted] LCSW Supt

MED CNY 455 (3/08)

RCTP Observation Monitoring Sheet

Patient Name: [redacted]	[redacted]	**C #:**	**Unit:** [redacted]
Date & Time of Transfer to Ob Cell: 9/6/09 11:30 AM	**Transfer Request:** [redacted]		
Transfer to observation cell from: ICP		(GP, SHU, ICP, TRICP, BHU, 4301 etc.)	

Reason for Transfer to ob cell: ☐ Threat of Self-Harm ☐ Self-Injurious Behavior ☒ Psychiatric Decompensation ☐ Assaultive ☐ Other

WATCH:	**Started:** Mo/Day Time	**Ended:** Mo/Day Time	**Signature:**
Suicide Watch (One to One)	__/__ __:__ am pm	__/__ __:__ am pm	
Restricted (5 min. rounds)	__/__ __:__ am pm	__/__ __:__ am pm	[redacted]
Regular (15 min. rounds) 9/7/09	__:__ am pm	__/__ __:__ am pm	

Patient should be provided with the basic minimum amenities as listed below. If a basic amenity is not provided, a clinical rationale should be given.

Basic Items	Date Given	Date Removed	Reason for non-approval or removal
Safety Smock	9/6/09	7/9/09	
Mattress			
2-Mats			
Footwear			
Eating Utensils (returned following meal)			
Soap (Return following use)			
Toothpaste (Return following use)			
Toothbrush (Return following use)			

Based on clinical determination indicate those additional amenities provided with date.

Additional Items	Date Given	Date Removed	Date Given	Date Removed	Reason for Removal or Justification for "Other"
Extra Mat					
Reading Material (without staples)					
Pen (bendable)					
Writing Paper					
Pajamas					
Underwear					
Shirts/Pants (Greens)					
Socks					
Blanket					
Other: Include Justification.					

NOTE: [illegible] IS STRICTLY FOR THE [illegible] TO ANY OTHER PATIENT. DESTRUCTION OF THIS MATERIAL IS REQUIRED [illegible] USE

Any allowed items not restored when clinically ready for transfer: Yes ☐ No ☐ **Reason, if yes:**

RCTP Coordinator Signature: [redacted] **Date:** 7/9/09

(RCTP) NURSING PROGRESS NOTE (OUTPATIENT) 353 MED CNYPC	NAME: (Last, First, M.I.) [redacted] C#: [redacted] DIN#: [redacted] Satellite Unit: [redacted] Housing Location: OBSO

DATE: 7/11/09	ASSESSMENT	DAY SHIFT	EVENING SHIFT
Hydration Assessment Per Patient:	Meals consumed: Fluids consumed:	B LUNCH D ☑Y ☐N ☐Y ☑N	D ☑Y ☐N
Direct Observation by Nurse or DOCS Staff:	Consuming meals Drinking fluid	☑Y ☐N ☑Per DOCS Staff ☑Y ☐N ☑Per DOCS Staff	☐Y ☐N ☐Per DOCS Staff ☐Y ☐N ☐Per DOCS Staff
	Drinking excessive amounts of fluid?	☐Y ☑N ☐Per DOCS Staff	☐Y ☑N ☐Per DOCS Staff
	Complaint of difficulty voiding?	☐Y ☑N ☐Per DOCS Staff	☐Y ☑N ☐Per DOCS Staff
Hydration Status	Lips	☑Moist ☐Dry	☑Moist ☐Dry
	Tongue	☑Moist ☐Dry, "coated"	☑Moist ☐Dry, "coated"
	Skin	☑Smooth ☐dry and scaly ☐"tenting"	☑Smooth ☐dry and scaly ☐"tenting"
Referral to DOCS Medical	Via referral form	☐Y ☐N ☑NA	☐Y ☐N ☑NA
Nutritional Assessment	Following 3 consecutive days of not eating/limited drinking, the patient's weight is obtained daily, and VS obtained as ordered	Weight_____ V/S N/A	Weight_____ V/S N/A
Pain Assessment	Complained of pain	☐Y ☑N	☐Y ☑N
Medication Compliance	Psychiatric Medications	☐Y ☐N ☑none prescribed	☐Y ☐N ☑none prescribed
	Medical Medications	☐Y ☐N ☑none prescribed	☐Y ☐N ☑none prescribed
Hygiene		☐Poor ☑Fair ☐Good	☐Poor ☑Fair ☐Good
Orientation		☑Time ☑Place ☑Person	☑Time ☑Place ☑Person
Dangerousness	Evidence of Self-Injurious behavior	☐Y ☑N	☐Y ☑N

Comments/Interventions (RN will identify shift, signature and title):

@8:54 PM [redacted] RN seen outside Degun SI/HI [illegible] & self harming behavior DOCS observation to OBSO. Denies SI/HI. Coming & going well. Escorted/escorted to RCTP/Transfer → at completion of the importance of following contacts in RCTP & how to redirect - verbalized understanding. Will continue to monitor. [redacted] RN

@ 5:45 PM Seen outside - See attached Progress Note — [redacted]

RN Signature [redacted] DATE: 7-11-09

350 MED CNYPC (1/97)

PROGRESS NOTES (OUTPATIENT)	Patient's Name: [redacted] C# [redacted] DIN# [redacted] Unit Name, Facility: [redacted] CNYPC
SERVICES: A	

A	Assessment	O	Other	SST	Support Skills Training
CM	Case Management	OT	Occupational Therapy	SM	Symptom Management
CS	Clinical Support	RT	Recreational Therapy	TP	Treatment Planning
CI	Crisis Intervention	R	Referral	VT	Verbal Therapy
DP	Discharge Planning	HT	Health Teaching	RRD	Rehabilitation Readiness Development
HSR	Health Screening/Referral	TPR	Treatment Plan Review		
MT	Medication Therapy	PRRD	Psychiatric Rehabilitation Readiness Determination	NCC	Non-Clinical Contact
ME	Medication Education			SHU	SHU Contact

NOTES: Indicate date, services, program, and as appropriate, goal/objective ID for each visit. Include signature and title after each Progress Note.

ıte & me	Svc & Prgm	GI/ Obj	
11-09 6:29 PM	OMH	A	@ 5:45 PM, patient is seen cellside. [redacted] denies S/H ideation and A/V hallucinations and states [redacted] is sleeping well. Fair eye contact. [redacted] rates [redacted] depression at 8 on 0-10 scale, 10 high. Placed on S.C., wanting A&D ointment for superficial scratches on [redacted] neck. Will continue to monitor. [redacted] [redacted] RN2

Note: Discharged on 6/22

353 MED CNYPC (Rev. 11/15/04)

(RCTP) NURSING PROGRESS NOTE (OUTPATIENT)	NAME: (Last, First, M.I.) [redacted] C#: [redacted] DIN#: [redacted] Satellite Unit: [redacted] Housing Location: [redacted]

DATE: 6/19/09	ASSESSMENT	DAY SHIFT	EVENING SHIFT
Hydration Assessment Per Patient:	Meals consumed: Fluids consumed:	B 100% L 100% ☑Y ☐N ☑Y ☐N	D ____ ☐Y ☐N
Direct Observation by Nurse or DOCS Staff:	Consuming meals Drinking fluid	☑Y ☐N ☑Per DOCS Staff ☑Y ☐N ☐Per DOCS Staff	☐Y ☐N ☐Per DOCS Staff ☐Y ☐N ☐Per DOCS Staff
	Drinking excessive amounts of fluid?	☐Y ☑N ☐Per DOCS Staff	☐Y ☐N ☐Per DOCS Staff
	Complaint of difficulty voiding?	☐Y ☑N ☐Per DOCS Staff	☐Y ☐N ☐Per DOCS Staff
Hydration Status	Lips	☑Moist ☐Dry	☐Moist ☐Dry
	Tongue	☑Moist ☐Dry, "coated"	☐Moist ☐Dry, "coated"
	Skin	☑Smooth ☐dry and scaly ☐"tenting"	☐Smooth ☐dry and scaly ☐"tenting"
Referral to DOCS Medical	Via referral form	☐Y ☐N ☐NA	☐Y ☐N ☐NA
Nutritional Assessment	Following 3 consecutive days of not eating/limited drinking, the patient's weight is obtained daily, and VS obtained as ordered	Weight V/S N/A	Weight V/S N/A
Pain Assessment	Complained of pain	☐Y ☑N	☐Y ☐N
Medication Compliance	Psychiatric Medications	☑Y ☐N ☐none prescribed	☐Y ☐N ☐none prescribed
	Medical Medications	☐Y ☐N ☐none prescribed	☐Y ☐N ☐none prescribed
Hygiene		☐Poor ☑Fair ☐Good	☐Poor ☐Fair ☐Good
Orientation		☑Time ☑Place ☑Person	☐Time ☐Place ☐Person
Dangerousness	Evidence of Self-Injurious behavior	☐Y ☑N	☐Y ☐N

Comments/Interventions (RN will identify shift, signature and title):
Days: Refused to speak to team, but willing to speak to [redacted] LT. [redacted] express feelings of broken heartedness & not wanting to ~~spec~~ return to unit & needing respite. in OR over the weekend, will cont. to monitor [redacted]
Evening: Remains calm & cooperative, reading in cell & resting. Affect bright at times & interactive w staff. Will cont. to monitor. [redacted], RN

Sec MD Consult 5/13/09

355 MED CNYPC 4/07

INITIAL PSYCHIATRIC EVALUATION PROGRESS NOTE
(X) MD OBSO (OUTPATIENT) ADMISSION NOTE
( ) MD OBSO RELEASE NOTE
( ) PRIVATE INTERVIEW ( ) CELL SIDE

Patient's Name: (Last, First, M.I.) C#: [redacted]
Date of Birth: [redacted] DIN#: [redacted]
Unit Name: [redacted] /RCTP UNIT
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Indicate date, time, program as appropriate, for each visit. Sign, title and date.

Date & Time | Program

( ) 4301 from ___ (24 hour) Seen together with M[redacted] S.W. (Primary Coordinator) with [redacted] SWT

CHIEF COMPLAINT AND CURRENT ISSUES:
Current Stressors- past few mos. not feeling right; been [illegible] of me belonging not usually bother me, it does, but now

PROGRAMS & Level of participation/functioning:
HISTORY OF PRESENT ILLNESS (include past hospitalizations, past medications and self harm):
Old Records available & reviewed-
Suicide gestures/threats/attempts: Cut self because I know it would allow
Self mutilation HX:
Past Outpatient Psychiatry:
Past Inpatient Psychiatry: Hx Schizophrenia in 1965
Past known DX's:
Past medications:
Time to see other women

MEDICAL ISSUES - CURRENT & PAST (include allergies): Sleep- poor Appetite- lost 20 lbs
"Heart Attack" (multiple surgical cuts on chest scars)
NKDA or Allergies:
Weight in lbs: Hx 140 lbs Height in inches: BMI:
( ) Pt. was taught significance of BMI in relation to Metabolic Syndrome, Diabetes and CVD
( ) Medical consult submitted ( ) Labs per protocols ordered
( ) AIMS ( ) EPS
( ) Last PE ( ) Updated PE requested

SUBSTANCE ABUSE HISTORY: Detox/Rehab HX:
ETOH usage: (X) per pt states drinks 2 DOLs per week
Illicit drug usage: per pt states smokes marijuana occasionally per chart review 6/24/06: 2 bags 300 pills (admitted to 30 g total > 30 g Elevated pH 5/09)

PERSONAL HISTORY (Include pertinent developmental, familial, social, occupational and legal issues)
Born & raised in: Family intact / not intact
Milestone accomplishment: WNL delayed: Married: Children: Trauma hx:
Education: Occupational HX:
Legal HX: Began- LO.

MENTAL STATUS EXAMINATION: General Appearance: neat clean
Relatedness: blk
Mood: depressed Affect: constricted Cognition/Orientation: (X 3)
Thought content: (X) Preoccupations: (X) future oriented
( ) overvalued ideas:
( ) delusions: ( ) suicidal ideation: (X) homicidal ideation:
Perceptual: ( ) auditory hallucinations: (X) visual hallucinations: (X) illusions:
Internal preoccupation: (yes) (no) Ability to qualify details of stated AH/VH
Thought form: coherent, less Insight/Judgment: (poor) (??) (good) Abstraction: (intact) (concrete) (yes) (no)
Impulsivity: (low) (mod) (high)
(Gross) Intelligence: (X) average ( ) below average ( ) Borderline ( ) MR (above average)
Memory: Recent (intact) Remote: (intact) Reliability of report: (good), (questionable), (poor)
Attention: good
Concentration: fair

(y) (n) - possibility of cultural assessment affecting the expression and/or interpretation of the above MSE?

.....continued on [redacted]

355 MED (CNYPC)

INITIAL PSYCHIATRIC EVALUATION PROGRESS NOTES (OUTPATIENT)

Unit [redacted]	Patient's Name (Last, First, M.I.)	DIN#	C#
Date & Time	Prof [redacted] (Continuation)		

SUICIDE RISK ASSESSMENT: ✓ *Low* ___ *Moderate* ___ *High*

RATIONALE/ PLAN (DESCRIBE): (As per CNYPC suicide risk protocol)

Rationale: Historical- none

Current- MDE c/w depression

Plan: ( ) Medicate, ( ) Supportive contacts/psychotherapy,

( ) Longitudinal observation, assessment, and planning ( ) RCTP placement

Other interventions ___

IMPRESSION/DIAGNOSES:

( ) DX's remain unchanged from therapist admission assessment

( ) DX clarification is in process: ( ) Differential DX's ( ) ADD DX's ( ) DELETE DX's

AXIS I: Major depression, single episode, severe

AXIS II: deferred

AXIS III: HTN, URI, Hep C

PLAN: List all current psychiatric and medical medications, including dose, route, frequency and indications:

(Include all current medications from prior unit/facility if applicable and any additions as appropriate):

Changes planned

OFF LABEL USE:
Indications:
OR Target symptoms:

Psychiatric Medications:

1. ___
2. ___
3. ___
4. ___
5. ___
6. ___

Medical Medications: (Indications-see 'Medical issues')

1. HCTZ 25 mg po daily
2. Lisinopril 5 mg po qday
3. Naproxen

( ) Pt. is (+) (-) compliant on current medication ( ) medication modification is req[redacted] due to: ___

( ) # ___ Antipsychotics ( ) # ___ antidepressants are prescribed due to:

1. ( ) Lack of efficacy to one agent ___ antianxiety agents
2. ( ) Partial response to one agent ___ mood stabilizing agents
3. ( ) Intolerance of higher doses of one agent
4. ( ) Reduce side-effects from higher dose of one agent only
5. ( ) Take advantage of synergistic effects

Rationale for a polypharmacy approach? ___

Use of High Dose Pharmacology:

1. ( ) Lower doses lacked efficacy
2. ( ) Lower doses resulted in Partial

( ) Low blood - drug serum levels (eg., rapid metabolizer)

Informed Consent: *** Discussed the following with the patient: treatment options alternatives and risk and benefits involved with taking medications.* ___ Check to verify

***Patient understands the risks and benefits of medications;* ___ Check to verify

Comments: Pt. taught Risks include:

1. (✓) mild discomforts
2. ( ) Extrapramidal side effects
3. ( ) Tardive Dyskenesia
4. ( ) Metabolic syndrome

( ) serious liver/renal damage
( ) need to monitor with serial labs
( ) potential for drug-drug interactions
( ) potential for priapism/sexual side effects

( ) Alternatives include the use of PSYCHOTHERAPY SERVICES ( ) Adjunctive use of Psychotherapy

( ) Pt. ___ verbalize all teaching done ( ) Pt. ___ receptive to teaching done

Other Therapeutic modalities: ___

ADDITIONAL INFORMATION: ___ ( ) *progress note attached*

Signature/Title: [redacted], M.D. (Staff Psychiatrist II)

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M.D. OBSO-(ADMIT) (RELEASE) NOTE
OBSO-(FOLLOWUP)
PSYCHIATRIC PROGRESS NOTE
( )M.D. FOLLOWUP NOTE
( )NEEDS DIAGNOSTIC CLARIFICATION

Patient's Name: (Last, First, M.I.) C#: [redacted]
Date of Birth: [redacted] IN#:
Unit/ Ward: [redacted]
Facility Name: CENTRAL NEW YORK PSYCHIATRIC CENTER

Instructions: Completed when indicated by the prescriber. Enter date and time of service. Document program (ie RCTP ICP etc.) if in outpatient service.

Evaluator R.C.T.P. Coordinators

Date 7/20/06
Time
Program
( ) GP
( ) ICP
(X) RCTP
( ) SHU
( ) PC
( ) KL

( ) PC seen in private interview by Prescriber ( ) and [redacted] [redacted] [redacted]

Attica CF

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Patient Name (Last, First, M.I.) [redacted] DIN# [redacted] C#

ASSESSMENT/PLAN: (Include changes to diagnoses and/or treatment options):

( ) # [redacted] on current medication ( ) medication modification is required ( ) RATIONALE ESTABLISHED FOR POLYPHARMACY APPROACH? (+) (-)

( ) # ____ Antipsychotics ( ) # ____ antidepressants are prescribed due to : ___antianxiety___mood stabilizer

1. ( ) Lack of efficacy to one agent
2. ( ) Partial response to one agent
3. ( ) Intolerance of higher doses of one agent
4. ( ) Reduce side effects from higher dose of one agent only
5. ( ) Take advantage of synergistic effects

(not applicable)

Use of High Dose Pharmacology:

1. ( ) Lower doses lacked efficacy
2. ( ) Lower doses resulted in Partial
3. (-) Low blood - drug serum levels (eg., rapid metabolizer)

(✓) Supportive Psychotherapy accomplished this visit — dismissed by unit

(✓) DX's remain unchanged ( ) DX clarification is in process ( ) Differential DX's ( ) ADD DX's. ( ) DELETE DX's

AXIS I:

AXIS II: = ASPD ?

AXIS III:

List of all current psychiatric and medical medications: (Include all current medications from transferring unit/facility including medical meds at the first visit after transfer. For subsequent notes, list all psychiatric meds and any changes to medical meds made since admission to this unit). Include does, route, frequency and indication for each medication listed.

INDICATIONS: (A)= see Axis I dx (T)= targetable symptom of....note:

Psychiatric Medications: * indicates off label use

1. Risperdal 0.5 mg po qhs (— (with dc
2.
3. (2 yrs has been in program, due for review 6/5/09)
4.

Medical Medications: Indications-see Medical Problem lists ( )MEDS UNCHANGED

1. 4.
2. 5. I see no Rationale
3. 6. to continue this patient receiving Rx for Non-FDA-Labeled use

Informed Consent:

Discussed the following with the patient: treatment options alternatives and risk and benefits involved with taking medications.

Patient understands the risks and benefits of medications: ___ Check to verify

Risks Include ___ Check to Verify

1. (✓) mild discomforts
2. (✓) Extrapramidal side effects
3. (✓) Tardive Dyskenesia
4. (✓) Metabolic syndrome

( ) need for serial lab blood draws due to risks of:

( ) Alternatives include the use of PSYCHOTHERAPY SERVICES ( ) Adjunctive use of PSYCHOTHERAPY SERVICES.

( ) Teaching literature reviewed and given to Pt. (verbally) (written materials)

( ) Pt. ____ verbalize all teaching done (✓) Pt. (not) receptive to teaching done

ADDITIONAL INFORMATION: Especially since unwilling to engage in needed Rx by unit

Emma Rice story until some omit ( ) 350 Med Progress Note attached

FOLLOW-UP: (Indicate next appointment): 1 Mo ( ) Per routine / per protocol

Signature/Title [redacted] (Staff Psychiatrist II)