NYC HEALTH+ HOSPITALS

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Derrick D. Cephas, Acting Chair
NYC Board of Correction
1 Centre Street
Room 2213
New York, NY 10007

Re: Variance Request to BOC Minimum Standards Regarding Seclusion: Section 2-06

Dear Mr. Cephas:

The New York City Health and Hospitals (H + H) requests a continuing variance from section 2-06(c)(1-3) of the Board of Corrections (BOC) Mental Health Minimum Standards which requires on-duty psychiatric coverage, the written order of a psychiatrist, and an examination of the inmate by a psychiatrist prior to the use of seclusion. Specifically, Correctional Health Services ("CHS") requests this variance to allow the use of seclusion upon clinical examination and direct written order of a licensed clinical psychologist.

According to the BOC Minimum Standards, seclusion is "the placing of inmates in their cells, or a seclusion room from which they cannot leave at will, during a normal lock-out period when other inmates in the housing area are given the option to lock out of their cells." Seclusion, as understood by CHS, is clinically driven, as opposed to security-driven Department of Correction-initiated "lock-in."

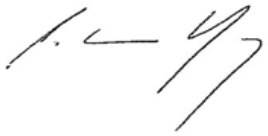
One of the core expectations of both patients and their clinical providers is the safety of the environment. The goals of psychiatric rehabilitation and recovery shared by patients and staff cannot be met in an environment where safety concerns overshadow treatment considerations. Seclusion is one of the tools available to the mental health service to accomplish these goals in situations where the patient-inmate presents as a danger to self or others and all other, less restrictive alternatives, have been tried.

To put this clinical intervention into practice safely and effectively, CHS requests a variance to allow licensed psychologists to initiate a seclusion order. Due to the staffing composition of the Mental Health Units, the requirement that seclusion occur only after an examination and order by a psychiatrist presents an extreme practical difficulty which would delay the initiation of this clinical intervention and increase the risk of harm to patients and staff. CHS Mental Health Units are managed by licensed clinical psychologists, who are therefore the mental health professionals most familiar with the patients in the units. The medical risks of clinical seclusion are minimal while under constant observation and licensed clinical psychologists are well-trained to assess imminent dangerousness, the resolution of imminently dangerous behavior (i.e., when the patient-inmate is safe to exit seclusion) and the need to contact additional staff (including medical and/or psychiatric staff) in the event of a worsening clinical or safety situation. For these reasons, the intent of the standard—that a patient is placed in seclusion for a limited time, and only after the evaluation and authorization by a licensed mental health professional familiar with the patient's treatment plan—is fulfilled.

The procedure to initiate and maintain clinical seclusion will remain the same; the only difference is that the order may be initiated upon examination of the patient-inmate by a licensed psychologist and a direct written order by the psychologist, which includes the reasons for taking such action.

We appreciate the Board's immediate consideration of this matter.

Sincerely,



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cc: Ross MacDonald, M.D., Interim Chief Medical Officer, CHS