Index No. 117882/99

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK, IAS Part 23

BRAD H., *et al.*,

Plaintiffs,

-against-

THE CITY OF NEW YORK, *et al.*,

Defendants.

SECOND QUARTERLY REPORT OF THE COMPLIANCE MONITORS

December 8, 2003

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SUPREME COURT OF THE STATE OF NEW YORK
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BRAD H., *et al.*,	:	
	:	
Plaintiffs,	:	
	:	
-against-	:	Index No. 117882/99
	:	Braun, J.
THE CITY OF NEW YORK, *et al.*,	:	
	:	
Defendants.	:	

Second Quarterly Report of the Compliance Monitors
December 8, 2003

By Order of the Honorable Richard F. Braun, dated and So Ordered on May 6, 2003, Henry Dlugacz and Erik Roskes ("Compliance Monitors" or "Monitors"), were appointed to monitor and report on Defendants' compliance with the terms and provisions of the Stipulation of Settlement ("Stipulation") resolving the outstanding issues in this cause. Per ¶149 of the Stipulation, the Monitors are to issue written reports every ninety days during the first year following the Implementation Date. This constitutes the second quarterly report of the Monitors.

Contents:

I. INTRODUCTION:

This report is being circulated as a final report. Due to time constraints related in part to the need to conduct the comprehensive investigation that led to the Special Report of November 17, 2003, we have been unable to complete this report in time to circulate it as a draft with a comment period for input by the parties.[1]

This report contains a large amount of data which was provided to us in a timely and responsive way by the Defendants. The data provided appears to us to be an accurate reflection of the data that is available to the Defendants, though at times we will call the validity of this data into question. Our questions about the validity of the data, however, should not be interpreted to mean that we are calling the Defendants' reporting of this data accurately into question, but at this point simply should be understood as concern regarding the process of data entry, data collection and data analysis.

II. ACTIVITIES OF THE MONITORS:

Since the date of our last report, we have engaged in the following major activities:

A. During this reporting period, we completed our comprehensive orientation to the systems in place for the provision of mental health care and discharge planning services to Class Members.

[1] Agreement was reached among the parties and the monitors at a meeting on June 25, 2003 concerning basic ground-rules governing the promulgation of monitoring reports: The Monitors agreed to endeavor to circulate draft reports, to be followed by a comment- period during which the parties could provide to the monitors their observations regarding the draft report. Following this period, the Monitors would issue a final report. This is essentially the process which we followed prior to the promulgation of our First Quarterly Report in September, 2003, as well as our Interim Report of November, 2003. In the absence of the consent of the parties to an extension of this time-line to permit a comment period, we elected to issue this Report without the comment period we would have preferred.

B. We continued discussions and successfully negotiated our contracts with The Mental Health Association of New York City ("MHA"), as the City's fiscal agent. The City's contract with MHA was registered with the Comptroller and our contracts with MHA were signed on September 15, 2003.

C. On October 8, 2003 Class Counsel informed us of the recent release from Department of Corrections ("DOC") custody and subsequent death of a Class Member. At the request of Class Counsel, we undertook an exhaustive interim investigation of the discharge planning services this class member received during his incarceration and the implications of his case to the overall system designed to provide these services.[2]

D. We interviewed Class Members and reviewed charts at three of the jails located at Rikers Island, including Eric M. Taylor Center ("EMTC") on 10/2/03, Rose M Singer Center ("RMSC") on 11/6/03, and Anna M. Kross Center ("AMKC")on 11/13/03.

E. We observed SPAN inreach sessions conducted at EMTC on 9/23/03 and 9/30/03.

F. We continued to meet with representatives of Defendant agencies, including Department of Homeless Services ("DHS") on 10/3 and 10/22/03, and the Human Resources Administration ("HRA") on 10/1/03.

G. We appeared before Justice Braun on 11/18/03 and participated in other conferences to facilitate the resolution of issues important to our monitoring functions.

H. We continued to meet regularly with Plaintiff's counsel on a monthly basis and have engaged in as-needed discussions with Counsel for the Defendants.

I. Upon finalization of our contracts and the availability of funds, we began to recruit and interview for staff positions and consultants.

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[2] This investigation culminated in a report, issued pursuant to ¶151 of the Stipulation entitled Special Report of the Compliance Monitors, dated November 17, 2003.

J. Upon finalization of our contracts, we began to develop performance indicators, a tool for use in regular monitoring, and a form for monthly statistical reports.

K. We participated in discussions and negotiation regarding access to Class Members' medical records.

L. We observed revised training for mental health staff on the assessment and documentation requirements regarding Seriously and Persistently Mentally Ill Class Members ("SPMI").

III. ORIENTATION TO THE DISCHARGE PLANNING SYSTEM AND ITS COMPONENTS AND OPERATION

Given the complexity of the system of care and discharge planning for Class Members, the Monitors undertook a thorough orientation to the various Defendant agencies. This orientation began immediately upon our appointment and was completed during the current reporting period. We conducted this orientation in several ways:

A. We attended a meeting on July 18, 2003 at City Hall with City Officials and key managers from Defendant agencies. At this meeting, each agency representative presented that agency's operational response to the litigation and settlement and provided us with information regarding how the agency intended to implement the procedures required by the Stipulation.

. This meeting was extremely useful in that we established relationships with these managers that have assisted and will continue to assist us in accomplishing many of our required

monitoring tasks. We gained an understanding of each agency's perspective on the challenges presented by the Stipulation as well as a sense of the various defendant-agencies' approaches for implementation of the Stipulation's requirements.

B. Department of Correction (DOC):

- We conducted a series of guided site visits in which we toured various facilities (especially treatment areas, including clinics and mental observation units, as well as areas where discharge planning services are conducted).
- We met and interviewed mental health and discharge planning staff at each facility. Importantly, we had the opportunity to talk in-depth with male and female Class Members to gain their perspectives on the delivery of services and to corroborate documentation contained in the records. During these meetings, we interviewed staff regarding the Brad H case, their roles within the case and the overall operations of mental health and discharge planning services in their facility.
- Where time and schedules permitted, we met with correctional management personnel. We have had meetings with Roger Parris, Deputy Commissioner, and Leroy Grant, Bureau Chief, Inspectional Services and Compliance Division, which have been particularly helpful in coordinating our visits to DOC facilities. These contacts have led to an arrangement with DOC whereby we have escorted access to clinical and housing areas in which we conduct monitoring.[3]

[3] We wish to express our appreciation to DOC for the excellent cooperation we received at all times to date in terms of access to the jails and to Class Members.

C. Department of Health and Mental Hygiene (DOHMH)

- As this agency oversees all mental health and discharge planning services, in many ways this agency has a threshold importance to the successful implementation of the Stipulation as a whole; as such, it is of primary concern to us as Monitors. We have developed an ongoing working relationship with Patricia Brown, Assistant Commissioner, Office of Forensic Services, who has primary oversight responsibility for the discharge planning services provided within DOC as well as with Michael Asch DOHMH's Director of Discharge Planning.
- We held a meeting with Lloyd Sederer, MD, First Deputy Commissioner for Mental Health, DOHMH.

D. Department of Homeless Services (DHS)

- The primary office within DHS which is of concern to this case is the Correctional Review Unit (CRU). We have had several meetings with the management of this unit, and they coordinated a visit and tour of various components of the Bellevue shelter.
- In addition, we met with Mark Hurwitz, Deputy Commissioner, in order to get a broader understanding of the services DHS provides to Class Members and others.
- We attended a meeting at the Bellevue Shelter, in which we discussed in greater detail the mechanism DHS has put into place for rapid recognition of Class Members and the various approaches DHS has for dealing with individuals with mental illness or co-occurring mental illness and addiction.

At this time, we also were given a tour of the shelter, which was useful in understanding the DHS system of care for homeless individuals with and without behavioral disorders.

E. Human Resources Administration (HRA)

- We held a meeting with the management of the HRA in order to better understand their approach to Class Members Medicaid and Public Assistance needs. We appreciated the attendance of Commissioner Eggleston at this meeting.

F. Finally, the Monitors visited contracted agencies that provide services to class members, including Service Planning and Assistance Network ("SPAN") and the various borough LINK agencies.

- We visited the five SPAN offices and interviewed staff and management of the contractor providing services in these offices
- We met with managers of the Borough LINK programs and have begun to arrange for visits to these programs to interview relevant staff and understand their operation vis-à-vis class members. To date we have visited the Manhattan LINK.

IV. MONITORING OF JAIL-BASED SERVICES

A. Site Visits:

Our reviews of the charts and conversation with mental health and discharge planning personnel on our visits to New York City jail facilities revealed the following[4]:

[4] We acknowledge that to date our sample size regarding chart reviews has been small and has been conducted in only three jails. While we do not wish to over-generalize from a statistically insignificant

1. Many charts we reviewed were chaotic and disorganized. At times, entries were neither arranged in some logical, categorical way, and entries were often not in chronological order. Such disorganization can contribute to fragmentation and reduced coordination of efforts. In our opinion, this will cause staff to be unable to readily find what they need in a class member's chart, which inevitably will lead to frustration and demoralization on the part of clinical and discharge planning staff.
2. Charts are at times hard to lay hands on due to multiple persons or clinics requiring them. This also contributes to fragmented, uncoordinated efforts, as staff must at times see the class member without access to updated and current medical and psychiatric information.[5] This has also been a problem when an outside agency or office (e.g. SPAN, the DP Community Referral Unit) needs information from a chart.
3. Some charts are missing critical information. As we have had limited time to review charts due to other prioritized needs, our "N" is small. However, it is clear that some of the key steps in the Stipulation are being missed on an unacceptably regular basis. One notable example is the absence of the Seriously and Persistently Mentally Ill ("SPMI") checklist in 7 of 16 charts - 44% - we reviewed in detail. This appears to us to be a violation of ¶24 of the Stipulation. This also calls into question the

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sample, we note that charts we did examine we reviewed jointly and exhaustively. Chart reviews were at times augmented by detailed joint interviews of Class Members. Our observations were relatively consistent from chart-to-chart and with each other and were congruent with comments made to us by staff members who have day-to-day experience with numerous charts, as well as the comments of Class Members.

[5] We noted a number of instances where psychiatric evaluations or other chart entries had the phrase "chart unavailable" written on the top, or with indications that a loose chart-note had been sent from jail to jail in an attempt to have the entry catch-up with the chart and the Class Member.

validity of any downstream finding regarding the prevalence of Likely SPMI ("LSPMI") or SPMI (see below)

4. Several of the charts we reviewed indicate significant problems in the understanding of Class Members and their needs. For example:
   - The charts evidence a lack of clarity as to Class Members' homeless status, with variable reports about this among different documenters in the charts.
   - There is also a lack of clarity as to class members' diagnoses, with similar variability among different documenters.

   While we recognize that different clinicians and interviewers may receive conflicting information when they interview class members, we are concerned that this may reflect poor communication among the many individuals involved in the mental health care and discharge planning services for each class member.
5. As least one documenters used a computer to generate progress notes. While on the surface this is a good idea, as these notes are more legible than many, at times we found formulaic progress notes. That is, each time that clinician placed a computer generated note in the chart; the note was identical, except for the date, to prior notes. Computers should not be used for this purpose: it is inappropriate for a note to simply be reprinted with a different date. Psychiatric patients change over time and this change must be reflected in charting, which should never be *pro forma*. Given that DP staff base their work with class members on the information

they find in the clinical chart, accurate and complete information is of the utmost importance; formulaic progress notes are of very limited use in planning for future care.

6. Documentation by discharge planners is frequently lacking in the details which would give a full sense of Class Member's individualized needs and situation. Many charts had only one note written by a discharge planner, indicating that the class member was interviewed and some documentation was completed. One chart, for example, indicated that an HRA 95 was started, but there was no follow up note to indicate that this form was completed and submitted or discarded as unnecessary. Similarly, one chart indicated that after a pre-screening was done and the reply indicated that HRA asked for a resubmission in the month of release, but this was not done, or if it was, it was not documented in the clinical chart.

7. Discharge planners reported to us that they have very high caseloads – as high as 200 cases. In part this is balanced by their carrying a number of Class Members on their caseloads who have refused discharge planning. The rationale for this is that Class Members who refuse discharge planning services at one point can always accept those services later. Keeping refusers on the caseload is an attempt to ensure that should a refusing Class Member be released suddenly, discharge planning services could be offered quickly.[6]

[6] Just before this report was submitted, we asked DOHMH to supply us with an average caseload size with breakdowns regarding different categories of Class Members, including active cases, refusers, and those who have been "deemed" (cf. ¶19). Given the

8. In some of the jails both mental health and discharge planning staff with whom we spoke indicated their services are not well coordinated. This was not the case in other jails, in which these staff appeared to be working closely together.

9. The role of LINK is unclear to at least some discharge planners. One discharge planner told us that she assumes that LINK handles all clinical and case management services "once we make a referral to LINK". This person professed no knowledge of what LINK does once they take over such a case. While we are not critical of the concept of turning over primary responsibility to LINK at this point, as LINK will be working with the class member upon release, we have concerns that the lack of knowledge on the part of the jail discharge planner about what LINK does is yet another manifestation of the overly rigid compartmentalization of discharge planning functions in the current system. For example, adequate discharge planning would entail preparing the Class Member for an initial meeting with a LINK worker by explaining what services the organization performs and what can be expected during the intake process. It is precisely this type of groundwork engagement which increases the likelihood that a Class Member will accept services in the first instance and follow through with the process over the course of time. This group of Class Members is especially important as only individuals who are SPMI are referred to LINK. Inasmuch as this is the group of class members

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time limitations we placed on DOHMH with the lateness of this request, they were unable to provide us with this information in time to be included in this report.

contemplated as the most seriously ill and therefore most in need of services, this sort of fragmentation raises significant concerns.

10. There are delays in meeting the timelines in some cases that result in inadequate or absence of discharge planning. For example, we found the following in one chart we reviewed:
    - The mental health initial assessment occurred in 5 days, not the 3 days required by ¶15.
    - The CTDP occurred in 16 days, rather than the 15 required by ¶17.
    - The discharge planner saw the person 5 days after the CTDP, rather than immediately as per ¶¶A.5., B.4, B.7. and B.8. of Correctional Health Service ("CHS") policy XI-C (Discharge Planning for Patients Receiving Mental Health Services)
    - As a result of the 8 days of delay, the discharge planner did not see the class member until the day before the class member's release and wrote a note indicating that it was "too late" to do discharge planning.

B. In talking with class members, we have found the following:

1. Class Members often have limited knowledge about the process of discharge planning, and many times cannot identify a person responsible for their discharge planning services. The reasons for this are not as yet clear but may include inadequate identification of discharge planners when meeting with Class Members.

2. At the same time, in our conversations with class members selected at random (e.g., every tenth name on the current census) or with specific criteria in mind (e.g. their appearance on a memo from Plaintiffs counsel, or their upcoming release date), we have found them in general to be notably receptive to our explanations of discharge planning services. This raises significant concerns regarding the number of apparent refusers and the approach to these Class Members made by mental health and discharge planning staff.[7] Our recommendations in our Special Report dated November 17, 2003 regarding staffing requirements and the staffing model are our first effort to try to remedy this apparent problem.

C. Summary of our findings and recommendations generated from our site visits to Rikers Island

We have concerns regarding the ways in which mental health and discharge planning staff approach a class member to discuss the various discharge planning services available. Given that we accept the observer-contamination paradigm (i.e. the presence of the monitors fundamentally changes the interactions and activities occurring in our

[7] We recognize on the one hand that Court Monitors coming in from outside the enclosed jail-setting may have a certain cachet which may cause Class Members to be more likely to engage with them; however, a discharge planner who has on-going contact with a Class Member has other distinct advantages over "outsiders" when attempting to engage a Class Member and gain acceptance of a needed service. We were struck by the receptiveness of the Class Member with whom we spoke to a wide range of discharge planning services after we explained the services and process with some specificity.

A related concern is language: a significant but unclear number of Class Members do not speak English, or are not sufficiently proficient in English to meaningfully participate in discussions regarding discharge planning. On most of our visits to the jails, we encountered Class Members who were unable to converse with us in English; as it happens one of us (HD) is conversant in Spanish and we were therefore able to engage some of these individuals in meaningful discussion with monolingual Spanish-speakers. Once we could do that, the Class Member's receptiveness to discharge planning increased. In the absence of the availability of discharge planning personnel and materials in each Class Member's primary language, it is expected that there will be a high refusal rate among individuals who do not speak English.

presence), we wonder whether the apparently high caseload size (though we are not certain at this time what the precise caseload size is) does not support the kind of quality case management that Class Members require. In addition, we have concerns about the separation and lack of coordination between mental health (who are the staff responsible for explaining discharge planning to a Class Member and obtaining that Class Member's consent to participate in discharge planning) and the discharge planning staff. If these two groups are not working in close consultation, it is hard for us to understand how the mental health staff will be able to persuade a Class Member to accept discharge planning services, as they are required to do by Correctional Health Services Policy XI-C, ¶A.7.

We believe that simply changing the service-delivery model to bring the CRU and Benefits Unit staff onto Rikers Island will increase the number of DP staff available, thereby decreasing the caseload. While we do have sufficient data to state that the resulting drop in caseload size would be sufficient to permit meaningful case management to occur, it would certainly be a positive start. This change in the model will also allow for the development of a single locus of responsibility. In other words, we recommend that the assigned discharge planner be responsible for all of the relevant activities for his/her cases, including the four various tasks currently divided among the Discharge Planning units. We believe that this will increase accountability and reduce the communication breakdowns which figured so prominently in our investigation of NA. We also support a higher level of training for the Discharge Planning staff. Discharge Planners with more clinical training and experience should be better able to engage with Class Members, including those who are initially

resistant to their efforts.[8] They will also be likely to become better integrated into the treatment (and aftercare) planning process. Finally, this model permits the DP to see the process through from start to finish, which will provide these staff with a better sense of accomplishment.

We recognize that Class Member movement among institutions may result in some discontinuity, as Discharge Planners are generally assigned by building. We believe that these discontinuities can be ameliorated in several conceptually simple ways: (1) use of the Discharge Planning Management Information System ("MIS") to which all Discharge Planning staff ***should have access*** and which ***should be live and online in all jails***, (2) use of email and phone communication to resolve questions that are not answered by the MIS, and (3) transmission of key information among the DP supervisors in the sending and receiving buildings.

Providing DP staff with access to the DP MIS would, in our opinion, begin to alleviate the disjointed nature of medical record keeping in the jails we have thus far visited. While it is clear to us that this situation ultimately demands the development of an electronic medical record capable of supporting multiple simultaneous users, we recognize that this solution is not likely to be achieved in the near-term. In the meantime, there is a functioning DP MIS containing much of the information that a DP needs – it is imperative to provide the DPs in the institutions with access to this system immediately. This system should be designed to provide "ticklers" when the various deadlines are approaching, in order to maximize compliance with the stipulation on the part of the DPs.

[8] Also of relevance to this discussion if the fact that some Class Member's primary language (or in some cases sole language) is other than English. We fully understand that many factors are correctly taken into consideration when retaining staff, but do assert this factor should figure prominently into the equation.

Finally, Defendants should assiduously pursue educational efforts regarding the litigation, the stipulation and the remedies under this case for line clinical and legal staff, both within Defendant agencies and contractors[9] and for outside agencies that serve class members and who could assist in discharge planning and access to care. Within the Defendant agencies, these efforts should include the systematic training of all relevant staff regarding key requirements of the Stipulation, such as the SPMI evaluation, and the role of the SPAN offices. Education targeted at outside agencies has been discussed above in the section V dedicated to SPAN services.[10]

D. Data regarding jail based services

1. According to DOHMH, 20% of all class members were SPMI. However, as indicated in our Special Report of November 17, 2003, and as noted above, in 7 of 16 charts we reviewed (44%), the SPMI checklist was not present. Recognizing the limited sample size, this is nonetheless a finding that causes us concern. In addition, as noted in our Special Report, staff often have ideas

[9] DOHMH does have two training sessions on the Stipulation scheduled later in December 2003 for the mental health providers, and, has agreed to make the text of the Stipulation available to mental health staff.

[10] On December 4, 2003 one of the monitors observed a revised SPMI training conducted on Rikers Island by Assistant Commissioner Brown of DOHMH. It was attended by approximately 20 mental health supervisors and senior psychiatrists and the Director of Mental Health for Prison Health Services. The monitor found the training to accurately reflect the relevant criteria for making this assessment. The handouts and PowerPoint slides were useful and informative, and, perhaps most importantly, there was a full exchange of questions and answers. The overall message conveyed by the presenter as well as the Director of Mental Health was of the importance of the SPMI assessment and on the need to ensure that any Class Member who falls within the definition of SPMI or Likely SPMI is indeed so designated. We suggest that this training be repeated for both supervisors and line mental health staff, and/or videotaped so that it can be reviewed by staff on various shifts and tours of duty. On a broader level, observing the training made clearer the degree to which the complete SPMI assessment – with its simultaneous emphasis on differential diagnosis and functional level outside of the structured correctional setting – constitutes a significant paradigm shift for the mental health providers in the jails. The task of ensuring that accurate SPMI and Likely SPMI assessments are completed will require substantially more than the issuance of a directive or policy. It will demand, rather, sustained training and supervision; the December 4th training was an important first-step in the right direction.

regarding the definition of the term "SPMI" that are very different from the legal definition promulgated by the State Office of Mental and built upon in the Stipulation. Thus, we suspect that the 20% rate of SPMI is on the low side and that there is a significant number of false negatives.

2. According to DOHMH, 32% of class members refused all discharge planning.[11]

CONCLUSIONS: While we fully understand and appreciate the difficulties inherent in engaging the targeted sub-group of the correctional population at issue in this case, to date have not seen evidence that Mental Health and Discharge Planning personnel are adequately working to overcome the predictable resistance demonstrated by some Class Members.[12] This high prevalence of refusal is not congruent with our experience working in correctional settings or in our monitoring work in this case, in which class members were more than willing to talk with us and even sign release of information forms after only a brief engagement time.

3. Analysis of book and case numbers revealed the following data regarding borough of arrest, for those in which the book and case number indicated a known borough (~82% of total). In addition, DOHMH supplied us with information regarding the borough of residence for a subset of the population for whom this data was available (~60% of total).

[11] We note that, of course, some Class Members do accept services in general, but still refuse specific categories of entitlements. Such Class Members are not included in the figure cited.

[12] While we respect individual autonomy and are fully cognizant of the legal right to refuse services, this right is only properly effectuated in the context of a system which makes reasonable attempts to engage the potential "refuser." Lack of insight and motivation are classic features of many mental disorders, and should not be taken at "face value." We have not seen adequate documentation of follow up attempts by mental health staff, who are tasked by current policy as cited above with re-offering discharge planning services at each meeting with a Class Member subsequent to any refusal of discharge planning services.

Table 1: Distribution of Class Members
by Borough of Residence and of Arrest[13]

	Borough of residence	Borough of arrest	
		In Jail	Released
Bronx	24%	23%	23%
Brooklyn	36%	25%	27%
Manhattan	24%	34%	35%
Queens	14%	16%	13%
Staten Island	1%	2%	2%

This data indicates that the proportion of class members living in and arrested in the Bronx, Queens and Staten Island is relatively similar. However, class members who live in Brooklyn are disproportionately arrested elsewhere, while a substantial portion of class members arrested in Manhattan live elsewhere. One caveat in interpreting this data is that it comes from different data sets: the residence data is the subset of the data from the November 3 data sent to us (Defendants could provide this data for 2651 class members). CONCLUSION: Borough of arrest provides a reasonable approximation of borough of residence in terms of the populations, albeit not necessarily at an individual class member level.

4. Analysis of length of stay (LOS) data: (Note: When deadlines *are* met, it can be as long as 11 days on an MOU and 19 days in GP before a class member sees a discharge planner.) Based on data from the Discharge Planning Management Information System (MIS) sent to us on November 18, 2003, 1440 of 5416 class members (27%) were released from jail 19 days or less after the remand date. See Table 2 below:

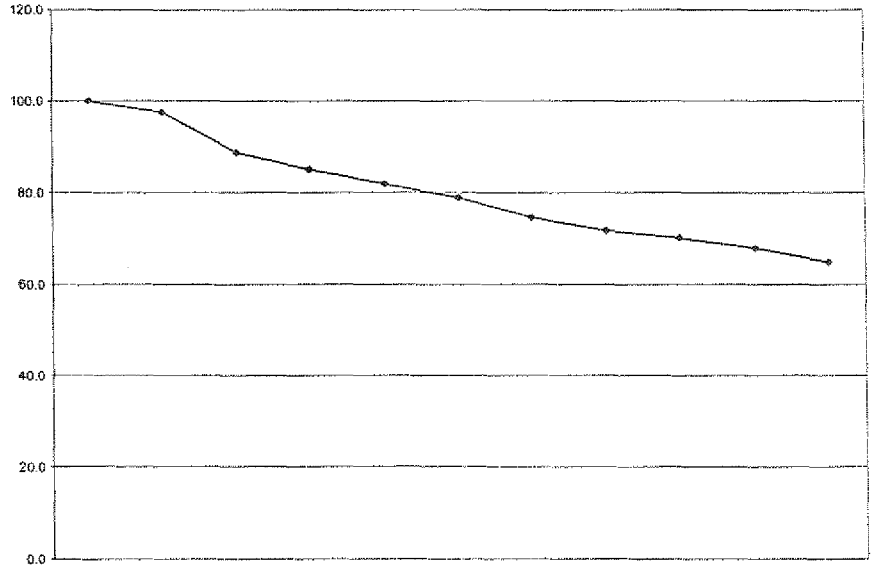
[13] In the two columns labeled "Borough of arrest, the numbers in the "in jail" column comes from the November 17, 2003 "In Jail" Data, and the second column from the November 17, 2003 "Released" data.

Table 2: Attrition of Class Members over Time

LOS (days)	# left	% left	Number released	% released
0	5416	100.0	0	0.0
3	5282	97.5	134	2.5
6	4807	88.8	609	11.2
9	4608	85.1	808	14.9
11	4505	83.2	912	16.8
12	4437	81.9	979	18.1
15	4273	78.9	1143	21.1
18	4042	74.6	1374	25.4
19	3976	73.4	1440	26.6
21	3883	71.7	1533	28.3
24	3797	70.1	1619	29.9
27	3676	67.9	1740	32.1
30	3509	64.8	1907	35.2

In our view, these data are important to keep in mind when determining discharge planning needs, and in planning for meeting identified needs over time. One third of class members leave the jail in less than 30 days, and one half leave in 57 days. The burden on discharge planners is great and clearly, based on our visits to the jails as well as on the data presented to us by DOHMH, not adequately met by staffing as currently configured.

Figure: Attrition Over the First 30 Days of Incarceration.



The Figure above indicates the rate of release over the first 30 days of an incarceration. As can easily be seen, the slope of this curve is fairly constant, indicating a steady rate of release over the first 30 days of incarceration. The only apparent change in this slope occurs between days 3 and 6 (the second and third data points). From this data, we conclude that there is no specific "key timepoint" that requires the urgent attention of discharge planners. Instead, it is generally imperative that class members be evaluated and plans made as expeditiously as possible, because during each day that goes by, a steady stream of releases occurs. Accordingly, on the whole, about 1% of Class Members are "lost" with each passing day resulting in a nearly linear graph.

CONCLUSIONS: It is evident that in a substantial number of cases, there is sufficient time between entry into and discharge from the correctional system for meaningful and important discharge plans to be developed and implemented. This statement notwithstanding, time is of the essence in performing these tasks, and compliance will not be achieved in the absence of an efficient, coordinated and energetic service delivery system.

5. According to DOHMH, pursuant to ¶¶10 and 11 of the Stipulation, telephone access has been arranged for members of the community to communicate information regarding class members to responsible offices within DOHMH. Between June 3 and November 20, 2003, a total of 23 such contacts have been logged. Copies of log sheets were forwarded to us for review and indicate that 19 calls from outside agencies were logged regarding 13 distinct class

members. Other calls logged indicated internal contacts among discharge planners, mental health staff, and the DOHMH Office of Forensic Services. CONCLUSIONS: Minimal use has been made of contact information by community members to date. Conceptually, the ability to provide this access is an important piece of a sound discharge planning model. However, while Assistant Commissioner Brown of DOH/MH reported that one particular call she personally took resulted in meaningful, on-going collaboration between the Department and a community service provider so that they could jointly provide assistance to a Class Member, our sense is that this opportunity should yield greater participation from members of the community be they family or outside treatment providers. We are hopeful that the use of this phone access will increase over time as it becomes known that the Defendants have a working mechanism to receive information from the community and to incorporate that information into mental health care and discharge planning of specific incarcerated individuals. One mechanism will be the community education sessions being conducted pursuant to ¶171ff (see section V. C. below).

6. ¶¶34-35 of the Stipulation requires defendants to undertake a pilot project in which discharge planners seek to determine from a class member's attorney that class member's projected release date. According to DOHMH, once the jail-based discharge planners obtain signed consent from the class member for this contact, the task of making the actual contacts has been delegated to the Community Referral Discharge Planning Unit (CRU). Per CHS policy XI-F,

"Processing of Attorney Consent Forms by Facility-Based Discharge Planning Staff", up to two phone calls are made, separated in time by 48 hours. If neither call results in direct contact with the class member's attorney, a letter is sent to the attorney "asking the attorney to contact the Public Health Educator concerning the inmate's release date".

Between June 2003 and November 15, 2003, attorney contacts were attempted in a total of 260 cases. See Table 3 below, based on information forwarded from DOHMH:

Table 3: Results of Pilot Project: Attempts to Determine Release Dates from Defense Counsel

	Results: Pilot Program June 2003 – November 15, 2003	Cases	%
1	Attorney contacted and unable to provide release date	116	44.6%
2	Attorney contacted but did not return call or respond to letter	81	31.2%
3	Attorney information unavailable	19	7.3%
4	Dates on IIS	17	6.5%
5	Consent received after discharge	13	5.0%
6	Attorney able to provide discharge date	9	3.5%
7	Client declined discharge planning service	4	1.5%
8	Consent received 1 day before transfer to state hospital	1	0.4%
	Total of attorney consent received.	260	100.0%

In only 9 (3.5%) of these total cases did the attorney provide a release date. However, for the purpose of data analysis, it is instructive to more fully analyze these data: in only 206 of these cases were attorney contacts attempted (i.e. lines 3, 4, 5, 7 and 8 can be excluded). Taking only those cases in which attorney contacts were attempted, the rate of success grows to 4.3%. The attorney was actually contacted only in 125 cases (lines 1 and 6). In 7.2% of these cases were the contacts successful.

However, it appears that only limited efforts have been made to pursue this pilot project. DOHMH advised us that they attempted contacts in all

cases in which the class member had signed consent for attorney contact. In some cases, the attorney was not identified by the class member and contacts could not be made. At times, class members were released before these contacts could be attempted. DOHMH was unable to advise us as to the absolute numbers of cases in which attorneys were unknown or in which consent was received but the class member was released prior to the contacts being attempted.

What is clear to us is that attempts to contact defense counsel do not begin until after the first CTDP is completed and the class member is referred to discharge planning. This means that Defendants will by definition not be able to contact about one quarter of the class members attorneys because of the attrition rate.[14] It also means that one third of the remaining class members will not have the opportunity to have their attorney contacted given the overall refusal rate for discharge planning.

According to data forwarded to us on a biweekly basis from the Discharge planning database, as of the November 3 data, there were 823 class members in AMKC and 591 class members in RMSC. In only 24 cases in AMKC and in only 130 cases in RMSC does this data indicate a projected release date. Thus, there could have been a total of 1260 (=(823-24)+ (591-130)) contacts attempted. An example of a case in which defense counsel provided a possible release date that should have been useful is the case that prompted our Special Report of November 17, 2003. Had the relevant discharge

[14] We recognize that discharge planning does not begin until the completion of the CTDP and referral to discharge planning. We comment on the attrition rate only to indicate a built in limitation to this pilot project, in that at most about three quarters of class members can become a part of this project.

planners been advised in a timely fashion of this release date, they could have worked with the class member in that case to obtain housing, clinical care and perhaps initiate benefits.

It is not clear to us (a) that reasonable efforts were made to obtain class member consent in all relevant cases (which we believe include all class members incarcerated at AMKC and RMSC who did not have a projected or known release date), and (b) what use was made of this information.

Our finding, pursuant to paragraph 35, is that the Defendants should continue this trial-period for an additional six months.[15] We suggest that efforts be made to more efficiently target sub-populations for whom this effort might be most useful. For example, we suspect without knowing, that attorneys will have more accurate information regarding release for Class Member charged with misdemeanors as opposed to felonies. Defendants may wish to conduct a statistical analysis to determine if they received a higher yield-rate for this (or other logical) sub-group in terms of Class Member willingness to grant permission for attorney contact, responsiveness of the attorney contacted, as well as the attorneys' ability to provide useful release-date related information.

7. Data regarding Discharge Planning tasks in the jails:

Data regarding a number of steps in the discharge planning process was provided by DOHMH. For the purposes of this analysis, we recognize that a

[15] We are unprepared to say at this time that either the project should be halted or that it warrants expansion to other facilities.

number of the data provided are faulty. For example: DOHMH reported that only 19% of eligible class members are reported to have had their CTDP's completed by the required timeline. Our experience with chart reviews does not jibe with this finding – implying that the database is not receiving accurate or timely input of datapoints. Another example where the data may not reflect reality is DOHMH's report regarding Medicaid prescreenings: DOHMH indicated that 159 class members had these done (5% of the total group), while HRA indicates that they received 1625 prescreens over the same time period.

Of over-riding importance here is the question of the validity of data the City collects and reports. The monitors and the parties must be able to reasonably rely upon the data produced and the City must work with the monitors to create mechanisms to ensure and check on the validity of any data provided. The dangers of doing otherwise are quite real: The monitors, in reliance upon the data produced, will conduct analyses, produce reports, draw conclusions and make recommendations which, despite the appearance of scientific specificity produced by percentages and figures, will inaccurately reflect the degree of compliance (or lack thereof) attained by the defendants. We cannot accept such a situation regardless of whether the data produced over or under reports the objective reality.

Having said that, there are some areas in which the data raises substantive concerns. Examples of this include the negligible rate of obtaining mental health clinic or other follow up appointments for eligible class members –

only 1%. Similarly, only 27% of the time did an eligible class member receive a referral to a mental health community program. Only 1% of eligible class members had a Medication Grant Program ("MGP") card upon release. These are among the key requirements in the Stipulation (and, indeed, in any system of designed to provide aftercare planning) and are among the performance goals. A third area of concern is that, according to the DOHMH database, there is an apparently very low rate of provision of medications and prescriptions on release. Only 115 (2.6%) of 4447 Class Members were offered "walking medications", and only 86 (1.9%) received them. Similarly, only 91 (2.1%) of this group received prescriptions on release. It is important to note at this point that not all Class Members are prescribed medication, so the correct denominator regarding the provision of an MGP card, walking medications and prescriptions should be something less than 4447. At this point in our analysis, we do not know what this denominator should be. It is imperative that these issues receive immediate and sustained attention. If the issue at hand it unreliable collection of data rather than such stark non-compliance as these numbers would seem to indicate, this, too must be remedied immediately; otherwise, the City will appear to be grossly out of compliance with performance expectations.

CONCLUSIONS: According to DOHMH's data, the required timelines are only rarely being met. It is our intention to develop a systematic monthly report in concert with the DOHMH database manager that will assist us in asking for information in a way which will be most informative and which

will reflect accurately the discharge planning services as they are being provided in the jails and at SPAN offices. This will consist of an iterative feedback process that will involve our work on the performance goals as we work to develop an appropriate data reporting mechanism. In our opinion, it is too soon to determine compliance rates, with a few exceptions:

- We are concerned with the finding that 32% of class members refuse **all** discharge planning services. The implication is that a greater percentage refuses selected discharge planning services. In our view, this in part represents inadequate attempts to engage clients, though we certainly recognize that there will always be some percentage of individuals in a correctional (and indeed in any) setting who will decline offered services.
- While we are unable to comment on the rate because we have not yet determined an appropriate denominator, we have concerns that only 34 class members had an appointment made prior to a known release date for a mental health clinic soon after that release date. Given that Defendant's report 1244 class members with a known release date, and assuming that there is a 32% rate of refusal of all services, we find a rate of 34/(0.68*1244)= 4% of non-refusers with known release dates had such appointments made. It is possible, of course, that many class members refused specifically this service; nonetheless it is of concern to us. Conversation with DOHMH indicates that they agree that this warrants additional investigation.

- We understand that there are many variables that feed into the provision of an MGP card to a class member on release. The relevant population appears to be those class members who are on medications on the day of release who then agree to accept medications and prescriptions at the time of release. Not all class members receive this benefit. However, the finding that only 32 class members received an MGP card raises concerns for us as it does for the Defendants.

8. According to the DOHMH database, there were 475 individuals identified as homeless between June 1, 2003 and October 31, 2003. Of this group, 77 (16%) appeared at a DHS shelter and were placed.

    - 31/77 (40%) were SPMI
        - 14/31 (45%) of this group went directly to a program shelter
    - 46/77 (60%) were not SPMI
        - 23/46 (50%) of this group went directly to a program shelter

    DMH further reported that they had completed and submitted 87 HRA 2000 applications. Ten of these applications resulted in determination that the Class Member was eligible for supportive housing, though it is possible that some of the feedback on these applications may have been received by other agencies (e.g. LINK) and therefore were not known to DOHMH. DOHMH was unable to determine the number of class members for whom supportive housing was available on the day of release.

    CONCLUSIONS: These results signify a very high degree of initial compliance with ¶96, **for those individuals who appear at a DHS site.** There are many reasons why class members who are reportedly homeless at

the time of release do not present to DHS, including their finding alternate housing with family and friends, self-referral to a hospital for evaluation/admission, re-arrest, and presenting to DHS under alternate identification. Nonetheless, it is plausible that a substantial portion of the 398 homeless individuals who did not appear at DHS were in fact homeless and chose not to utilize the shelter system.

9. Medicaid: DOHMH data indicates that 159 Medicaid Prescreenings were completed within the 3 days allotted for this task by the Stipulation. In contrast, information forwarded to us on November 21, 2003 from HRA indicates that a total of 1625 Medicaid Prescreenings from the jails were received as of November 15, 2003. HRA indicated that 527 (32.4%) of these class members still had active Medicaid. An additional 31 (1.9%) had active Medicaid but needed and were given recertification. A total of 542 (33.4%) had their Medicaid reactivated. A final group of 525 (32.3%) required new Medicaid applications.

Between June 1 and November 15, 2003, a total of 474 Medicaid applications were processed. Of these, 379 were received during this time interval. Thus, 28% of the class members known to need new applications did not have them done. Of the 474 applications that were processed, 341 (71.9%) were found to be Medicaid eligible, and 133 (28.1%) to be Medicaid ineligible. Extrapolating, this means that 71.9% of the 379 applications received by HRA and processed, representing 273 class members, were found to be Medicaid eligible. In contrast, 28.1%, or 106 class members, were

determined to be ineligible for Medicaid. DOHMH's data here too appears to be incomplete, in that they report that a total of 35 Medicaid applications were submitted to HRA, not the 379 that HRA is reporting.

CONCLUSIONS: First, the data differential between DOHMH and HRA is a problem and should be resolved. Per discussions with DOHMH, we have concerns regarding the data collection and data entry processes. We recommend that DOHMH and HRA hold discussions regarding this difference to try to remedy the difference.[16]

A total of 5416 class members were released between June 3, 2003 and 11/15/2003. Of this number, 3853 had a length of stay 23 days or longer and were eligible for discharge planning services.[17] Only 1625 prescreenings were done, indicating that 57.8% of those class members eligible for prescreens **did not have them done**. Clearly, this is an unacceptable finding. The performance indicators mandated in the Stipulation include the prescreenings as one of the key indicators; this will be an area of close scrutiny in our monitoring efforts.

Further, only 273 class members of the 525 determined to need new Medicaid applications were ultimately found eligible. Because only 379 of the 525 class members who needed a new application had this done, and assuming that the same 72% eligibility rate would hold for those not having

[16] We suggest that the collaborative effort which will be required to reconcile these data should reflect the overall inter-agency effort and enhanced communication which will be required on the substantive level to achieve the implementation of the Settlement.

[17] This finding is taken from the DOHMH database. The assumption of 23 days or longer is based on the assumption that by day 22, all prescreenings should be completed (see ¶¶ 14-17, 59 for relevant timelines). Note that this finding is a minimum finding as those class members housed on an MOU would be eligible for discharge planning services at day 8, well before day 20, so that our conclusions represent conservative, Defendant-favorable conclusions.

the applications submitted would have been eligible, 104 class member who might have been found eligible did not have this benefit made available to them.

10. Public Assistance: DOHMH indicated that 5 public assistance applications were submitted within 5 days of the CTDP. HRA advised us that a total of 164 public assistance applications were received, and a total of 172 were pended. A total of 30 class members appeared at a Job Center. Seven of these 30 had their applications filed while in DOC, while 23 had them filed either with the assistance of SPAN or by appearing at a Job Center and self-identifying as a class member. Of these 30, 18 received some type of public assistance benefit. Thus, 18 of 164 total applications (11%), and 18 of 30 who appeared at a job center (60%) received benefits.

CONCLUSIONS: As above, the discrepancies between DOHMH and HRA data must be reconciled. In addition, it is imperative that discharge planners offer and complete applications for public assistance for those class members who are identified as SPMI and who appear to be eligible for such benefits. Between June 3 and October 31, 2003, a total of 3502 class members who spent 25 days or more incarcerated were released.[18] Data provided by DOHMH indicates that 20% of class members were found to meet criteria for SPMI. Assuming that this percentage holds for class members released before day 25 and after day 25, there should be a total of 700 SPMI class members for whom public assistance benefits should be considered. Only 164 of these class members had an application received at HRA (23%), and this also

[18] See above footnote and ¶¶ 14-17, 78 for relevant timelines.

assumes that the 164 applications were received on 164 separate individuals and that there were no reapplications at the end of the pending period.

11. Follow-up Contacts for SPMI Class Members: We have been advised by DOHMH that only recently have they begun to track the follow-up contacts required by ¶¶49 and 100 in the Stipulation. Therefore, though the numbers appear low, we are reluctant to make any findings or recommendations other than to strongly encourage Defendants to continue to track this and to consult with us as we develop the performance indicators related to these requirements.

SUMMARY OF FINDINGS (see Table 4)

Table 4: Sample Findings from Defendants' Data

Task or Datapoint	Finding
Use of Defendants' Telephone Contact by Community	minimal
Use of Monitors' Telephone Contact by Community	minimal
Completion of CTDP in allotted time	19%
SPMI prevalence	20%
Rate of Refusal of DP services	32%
Daily Attrition Rate	1% per day
% left on day 11	83%
% left on day 19	73%
# of release dates learned from defense counsel	9
# of appointments made prior to release	35
Rate of Direct Admission to Program Shelters	48%
Compliance Rate for Medicaid Prescreening	42%
Compliance Rate for PA applications	23%
# of MGP cards provided on day of release	32
Rate of receipt of walking meds on release	1.93%
Rate of receipt of prescriptions on release	2.05%

a. There is a 32% rate of refusal of discharge planning services. We have concerns that this high refusal rate may reflect inadequate

attempts to engage the population of class members. We recommend that, as a part of any changes that are contemplated, reducing this rate of refusal be strongly addressed.

b. During the first 30 days of incarceration, about 1% of the class leaves the jails each day. The rate is fairly constant over this interval. This has two major implications

    i. There is no time point which is crucial

    ii. All time points are equally crucial, and the more quickly discharge planning efforts are brought into play, the more successful these efforts will be in reaching the largest possible group of class members.

c. Minimal use has been made of telephone contact points by community members regarding class members. This is true both for the DOHMH contact number and for the Monitors' phone line.

d. DOHMH provided us with data indicating extremely low compliance rates with a variety of the steps in the discharge planning process.

e. There is a high rate of compliance – near 50% - with ¶96, requiring expedited placements of homeless class members into program shelters by DHS.

f. 42% of individuals eligible for a Medicaid prescreening had this done.

g. Defendants submitted Public Assistance applications to HRA for 23% of SPMI Class Members.

h. There is an apparently very low rate of provision of medications and prescriptions on release, according to data provided from the DOHMH database.

V. MONITORING OF SPAN SERVICES

A. SPAN provided the following breakdown regarding its utilization between June 1 and October 31, 2003:

Table 5: SPAN Visits by Borough and Services Provided.

Borough	# of visits
Brooklyn	67
Bronx	33
Manhattan	44
Queens	33
Staten Island	14
Total	191

Service Provided	#
Clinic appointment	135
Medicaid application	74
MGP cards issued	78
PA application	8
DHS referrals	23
HRA 2000	1
Medications	28
Total	347
Services per Client	1.82

From June 3 until October 31, 2003, DOHMH reported a total of 191 SPAN visits. As of October 31, 2003, there were 4985 Class Members released from the jails, according to data forwarded to us from DOHMH. Thus, 4% of eligible individuals visited a SPAN office.

The median and modal number of visits per class member was reported to be 1, indicating no multiple-visit interventions by SPAN. The number of services per class member was just over 1.81, indicating that

the majority of class members who visited SPAN had two of the available services provided to them. It is important to note here that our request for this data was very close to the due date of this report and that due to this timing, DOHMH and SPAN were unable to get us data on all of the services SPAN provided. Therefore, the number of services per Class Member should be considered an underestimate.

Use of SPAN by borough reveals some interesting comparative data.[19]

Table 6: SPAN Visits by Borough Compared to Borough of Arrest.

Borough	% of total SPAN visits	% of population arrested in borough	% of population residing in borough
Brooklyn	35%	27%	36%
Bronx	17%	23%	24%
Manhattan	23%	35%	24%
Queens	17%	13%	14%
Staten Island	7%	3%	1%

Table 5 indicates that SPAN is more likely to be used in the borough of residence than in the borough of arrest, given how closely the last column resembles the first.

B. We have observed SPAN inreach sessions conducted pursuant to ¶39 of the Stipulation. These inreach sessions have reportedly reached a total of 195 class members, 25 of whom (13%) have used one of the SPAN offices. According to the DMH database forwarded to us on November 3,

[19] We note that this methodology has an area of imprecision, in that the home-borough of the class member was taken from the book and case number. This number reflects the borough of arrest and not necessarily the borough of residence. Nonetheless, we think this a worthwhile start at an important analysis which we will refine and expand upon in coming reports as needed.

2003, a total of 4986 class members were released from DOC during the time period between June 3 and October 31, 2003. Thus, 4791 class members did not have a SPAN inreach contact. Of this group, 170 (3.5%) visited SPAN. It appears that the SPAN inreach sessions increase the utilization of SPAN by nearly 4 times. This finding is not surprising to us given our observations of two SPAN inreach sessions. The sessions were conducted in a manner which clearly made attempts to engage CM's. They were informative, inviting, and explained the services in a manner likely to be understood and appreciated by the target population. Further, Spanish-speaking staff was available to speak with monolingual, Spanish-speaking CM's.[20] Our experience in observing these sessions indicates that it is difficult if not impossible to predict which of a group of class members will follow through and utilize a SPAN office; at times, the individuals who might be predicted to be least likely to avail themselves of this service do in fact come to SPAN, while those who evince during the inreach an absolute desire to use SPAN do not appear. Thus, we conclude that the SPAN inreach sessions are highly valuable and must continue.[21]

[20] Frankly, this is the overall approach we recommend for discharge planning staff in general, which if utilized we suspect will lead to a greater acceptance rate for services.

[21] An issue arose at both sessions observed about which we continue to seek clarification from DOC: Several CM's requested business cards or other written handouts indicating the precise location of SPAN offices. The SPAN workers were under the impression that security concerns precluded them from responding positively to these requests. We are convinced that passing out brochures or cards with maps on the back indicating the location of SPAN offices in relation to the courts, subways and other key locations would likely increase utilization of SPAN. On Thursday, December 4, we were informed by representatives from DOC that such materials would be acceptable to DOC from the standpoint of security. We strongly encourage Defendants to develop appropriate public education materials such as those we have described for use in DOC to ensure that Class Members are aware of the SPAN offices and the services available to them upon release.

C. Several concerns regarding SPAN, specifically related to general knowledge of SPAN by personnel inside and outside the correctional mental health care environment, were noted in the Special Report of November 17, 2003. During that investigation, it became clear that treatment staff within DOC were not fully aware of the important role of SPAN given the uncertain nature of release from incarceration. Additionally, some personnel from outside agencies that are important in the overall management of a class member (e.g. defense counsel) were apparently completely unaware of SPAN. Finally, the class members themselves during our interviews appeared to be unaware of SPAN, both by name and by function when we described SPAN to them. While inreach sessions clearly make a difference, as noted above, it is evident that these inreach sessions will only reach a tiny minority of class members.

Therefore, we conclude that significant attention should be paid to the knowledge base of all mental health and discharge planning staff regarding SPAN. One recommendation to be considered would be to have SPAN conduct trainings with mental health staff in the jails they visit during their inreach sessions. Another activity which has begun and should continue is the effort to educate relevant community agencies pursuant to ¶171ff in the Stipulation. Defendants have sent information regarding SPAN to 682 agencies and organizations. (Many agencies have not responded to these mailings.) We understand that to date, Defendants

have conducted 15 such trainings at Criminal Justice agencies (e.g. Courts, prosecution and defense counsel, probation and parole agencies) and at Mental Health agencies (e.g. treatment providers, case management agencies, residential and housing providers) and that 5 more have been planned. These should continue, with special attention paid to educating as many defense counsel agencies as possible given the role these professionals have in causing class members to be released from incarceration.

D. We are required to review the utilization of the SPAN offices after 6 months. Per ¶36, Defendants may modify the hours of SPAN operation with our consent. At one point, the director of the SPAN program advised us that there had been no utilization of SPAN after 5pm. Defendants have not, however, approached us regarding changing the hours of operation of SPAN.

At this point, we would be reluctant to assent to such modification, which view as premature given the low utilization rates and the still incomplete efforts to educate Class Members and the Community regarding the services SPAN offers. In our view, there has not been sufficient experience to make a determination regarding the hours of operation.

VI. REVIEW OF FINDINGS AND RECOMMENDATIONS FROM OUR NOVEMBER 17, 2003 SPECIAL REPORT

In our Special Report of November 17, 2003, we made the following recommendations in the aftermath of the death of a class member a few days after his release.

1. There is a need for a determination as to whether individuals who, immediately after arrest, are hospitalized on one of the prison units qualify as class members at the time of his/her admission to the prison unit
2. Defendants should work to develop a single point of responsibility for the mental health care and the discharge planning for each class member.

3. Defendants should work to improve communication and communication technology. These improvements, in our view, are absolutely essential to the success of all discharge planning efforts. It is unacceptable for discharge planning staff, wherever they are located (including SPAN), not to have immediate, real-time access to the Discharge Planning MIS. Similarly, to be successful in discharge planning efforts, discharge planning staff must have electronic mail and fax capabilities, reliable hardware and software with rapidly responsive maintenance services, and voice mail.

4. Education for staff responsible for delivery of discharge planning services and for outside agencies, as has been discussed elsewhere in this report.
5. Develop a better mechanism to get medications to court-released class members

VII. CONFIDENTIALITY AND ACCESS TO RECORDS

The issue of the interplay between Federal and New York State confidentiality laws and our access to Class Members' records has arisen in various permutations throughout the monitoring of the Settlement, and was the subject of briefing by the parties for the Court.[22] Currently, subject to a Stipulation and Interim Order submitted on consent of the parties to the Court on October 27, 2003, we have access to the medical records of Class Members with the following limitations: We are precluded from copying substance abuse-related information contained in the records (although we can review this information), and we are precluded from even receiving HIV-related information (Exhibit A). This temporary arrangement has removed the truly crippling limitations under which we were previously laboring; nonetheless, it is clear to us that, given the prevalence of HIV and substance abuse issues in the population, we are unable fulfill our obligations fully in the absence of complete and unfettered access to all medical records of class members.[23]

While we have the greatest concern for maintaining confidentiality of information protected by law or ethical standards, we believe that ¶¶150 and 159 and our executed

[22] We understand from counsel that the briefing on this issue has been completed, with a return date on January 15, 2004.

[23] For our purposes, the term "medical records" include all records pertaining to the medical and mental health needs of a Class Member.

confidentiality agreements, as well as the ethical standards of our respective professions, adequately protect the confidentiality of the information contained in the records we review.

We note that in addition to the issues regarding class medical records we raise above, our access to the DOHMH and related databases has been delayed by this unresolved issue. We are hopeful that this difficulty will be resolved in the near future so that we can (a) gain full access to the information we require; and (b) so that we can create the data collection structures which will allow us to receive the information we require in an on-going, systematic and comprehensive fashion.

VIII. MEDICATION LIST

Per ¶27, we have compiled a list of medications used to treat psychiatric conditions (Exhibit B). This list is designed to be used by mental health staff in completing the likely SPMI determination pursuant to ¶27. This list was forwarded for review and comment to DOHMH and to the Director of Mental Health for Prison Health Services by electronic mail on September 7, 2003. As required by ¶27, we will update this list at least annually. DOHMH advised us that they distributed this list at that time. They have been using a daily pharmacy list provided by CHS. By crossmatching this list with the medication list we provided on September 7, 2003, those class members taking medications on the medication list had their records updated in the DMH MIS:

- The client record was flagged as "receiving medication in jail for mental illness
- The client was identified as a designated class member as of the first date such medication was dispensed, and

- The client was designated as "likely SPMI" as of that same date.

According to DOHMH, this process occurs daily.

As a part of the process of clarifying this ¶27 and the use of the medication list, we posed the question of "bridge orders" to Defendants. A bridge order is a short-term order for psychiatric medications, written by a non-psychiatric physician or physician-extender (e.g. physicians assistant or nurse-practitioner), to ensure continuity of medication treatment for individuals coming into DOC already on medications and when a psychiatrist is not immediately available. Defendants agreed that patients on listed psychiatric medications pursuant to such orders should be determined to be likely SPMI under ¶27.

Paragraph 27 also contemplates that some class members classified as likely SPMI based on prescription of medications on the list and will later be determined not to be SPMI, with documentation of the rationale for this change. To date, we have not encountered such a case; therefore we are unable to determine Defendants' compliance in this area.

IX. WMS ACCESS (¶62)

On February 28, 2003, pursuant to ¶62 of the Stipulation, Deputy Mayor Dennis Walcott wrote to the New York State Health Commissioner to request access to the Welfare Management System (WMS). After two conference calls, the Deputy Commissioner in the Office of Medicaid Management at the New York State Health Department responded on September 9, 2003 that due to privacy and confidentiality

regulations, only HRA staff are permitted access to WMS. The request for access by the Benefits Unit and by SPAN was denied.

We are required to comment on the feasibility of obtaining access to WMS at the Benefits Unit and at SPAN. At this point, while Defendants have made an attempt and appear to be blocked in their attempt to obtain this access, it is not clear to us that all attempts to do this have been exhausted and therefore are not prepared to comment on the feasibility or lack thereof.

X. FOOD STAMP ELIGIBILITY (¶86)

Defendants have engaged in a series of correspondence with the United States Department of Agriculture regarding the timing of applications for food stamps. At this time, the outcome of Defendants' request is still in question, as a final answer has not been forthcoming. To our knowledge, the following has occurred to date: On June 10, 2002, HRA Commissioner Eggleston wrote to a Deputy Undersecretary of the U.S. Department of Agriculture requesting her assistance in implementing a program to provide Class Members in *Brad H* who are determined to be SPMI with access to food stamps and public assistance immediately upon their release or soon thereafter. The letter references discussions which had apparently taken place prior to the date of the correspondence, and discusses, among other matters, the limitations placed upon HRA by the Welfare Management System ("WMS"). In sum, the Commissioner requested – in our opinion, forcefully and effectively – approval of the USDA to accept an application for food stamps from eligible Class Members prior to their release so they might avail themselves of these benefits when they are released or soon after that time. She further

requested permission to "pend" such applications in cases where the Class Member remains incarcerated for more than 30 days following the application. The Undersecretary responded in a letter stamped July 10, 2002 indicating that she had directed her staff to research alternatives and work in tandem with HRA on this matter. She, further, appointed the Regional Administrator for the Northeast Regional Office of USDA as the contact person for these efforts. Commissioner Eggleston wrote to this point-person on September 18, 2003 to follow up on this matter. As far as we are aware, she has not yet received a response, but counsel advised us that Defendants' will continue to pursue this issue.

XI. ACCESS TO SSI AND VETERAN'S BENEFITS (¶87)

According to Defendants, the focus on development of an operational structure and relevant procedures and policies for a more integrated discharge planning effort have delayed exploration as to how Defendants might facilitate the assessment of SPMI class members for federal benefits. According to Marjorie Cadogan from the Mayors Office of Health Insurance Access, the affected agencies plan to open discussions about "operational elements, approvals and policy changes needed to make such an assessment possible and examine their feasibility as part of the discharge planning process for class members."

XII. PERFORMANCE INDICATORS

A draft of the performance goals, mandated by ¶¶140ff, will be circulated on December 8, 2003, for comment by the parties. After reasonable consultation with the parties, as per ¶147, we will promulgate a final version. We note here that ¶144 permits the Monitors to establish performance goals in other areas as necessary to effectuate the terms of the Agreement. It is our intent to monitor Defendants' compliance with performance indicators and to add or eliminate performance indicators based on ongoing monitoring of said compliance.

XIII. CONCLUSION AND SUMMARY

This concludes our Second Quarterly Report. In closing, we will summarize some of our findings and the limitations of the conclusions that we have drawn.

First, it is clear that Defendants have made immense efforts to date in bringing about change within the system that provides discharge planning services to class members in the jails of New York. While we remain critical of various areas of the actual discharge planning process, as well as fundamental aspects of the service-delivery model, this in no way should be interpreted to mean that we believe the Defendants are not making good faith efforts.

Some of the content areas where we believe Defendants fall short at this stage of the remediation of discharge planning services include:

- Data collection and reporting inadequacies. This problem is very serious in that any measures are called into question if the validity of the data is not solid and reliable. **Data is one of the fundamental aspects of our monitoring approach and must be made reliable and valid.**
- Inadequate coordination between entities working with class members. This has been evident in the following dyadic relationships that have not appeared to promote collaborative care of the class member with attention paid to appropriate discharge planning:
    - Mental health-Discharge planning personnel within the jails.
    - Jail-based discharge planning-CRU/Benefits unit. This collaboration is overly reliant on potentially undependable communication technology. We have recommended and continue to recommend that adequate infrastructure and communication technology be provided for these staff.
    - Discharge planners-outside agencies. This is an important collaboration that the Stipulation emphasized. DOHMH and Plaintiff's counsel have conducted some educational sessions and more are scheduled. These should assist community agencies in understanding the system changes that have happened and that will

happen and should promote interagency collaboration regarding discharge planning for class members.

- Clinical and discharge planning recordkeeping in general is not sufficiently organized, to overcome the disjointed nature of the current discharge planning system. This produces uncoordinated efforts when work is being done with a class member and results in inadequate discharge planning. We recommend that an electronic medical record be implemented that would allow multiple simultaneous users to read and write to the record. Until this is developed, at the very least, the DOHMH discharge planning MIS should be available to all discharge planners in all jails. This would provide them with more up to date information and reliance on a single point of contact will be unnecessary.
- There are a number of areas in which compliance rates appear to be very low. This may in part reflect inadequate data collection on Defendants part. This has been reviewed in detail above in section D and will not be repeated here.

Process concerns include:

- There remains an ongoing inability of the monitors to fully review the medical records of class members. While the parties have resolved this in part, we believe that
    - ¶¶150 and 159, our signed confidentiality agreements, and the ethical standards of confidentiality of medicine, social work and law all provide adequate protection of the confidence of the information we will obtain in viewing these records; and

- we are unable to fully comply with our obligations under ¶¶120ff of the Stipulation.

We strongly encourage a speedy resolution of this issue in favor of our unfettered access to class member records.

NEXT STEPS: Concurrent with or shortly after our release of this Report, we will be releasing in draft form the following documents for comment by and consultation with the parties in their development and finalization:

- Performance Measures, pursuant to ¶140ff.
- Request for a Monthly Statistical Report from Plaintiffs

Finally, we intend to adhere to the following schedule for all subsequent **regularly scheduled** reports:[24]

Request special data from Defendants	6 weeks prior to due date
Circulate draft of report	3 weeks prior to due date
End of comment period	10 days prior to due date
Publish final draft of report	due date

We hope that this report is useful to the Court and the parties.

Respectfully submitted,

Henry Dlugacz
Compliance Monitor

Erik Roskes
Compliance Monitor

[24] We may adapt this schedule in the event we are asked to submit such a Special Report or undertake other substantial consultative or investigative task,

Exhibit A

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

----------x

BRAD H., ROBERT K., MICHAEL R., SUSAN T., and KEVIN W., on behalf of themselves and all others similarly situated,

Plaintiffs,

- against -

The CITY OF NEW YORK, et al.,

Defendants.

----------x

Index No. 117882/99
IAS Part 23
(Braun, J.)

STIPULATION AND INTERIM ORDER

WHEREAS, the parties settled this action by Stipulation of Settlement dated January 8, 2003 ("Settlement");

WHEREAS, the Court approved the Settlement by Amended Final Order and Judgment issued April 4, 2003;

WHEREAS, pursuant to the Settlement, the Court appointed two Compliance Monitors by Order issued May 6, 2003, to monitor defendants' compliance with their obligations under the Settlement, as set forth more fully in the Settlement;

WHEREAS, pursuant to the Settlement, the Compliance Monitors are entitled to request from defendants documents and information, as more specifically identified in the Settlement, that are reasonably necessary to determine whether defendants are complying with the Settlement ("Compliance Documents") including, but not limited to, Class Members' Mental Health Records, as that term is defined in the Settlement, and records concerning Class Members maintained by the New York City Human Resources Administration and/or Department of Homeless Services;

WHEREAS, defendants believe that such Compliance Documents concerning Class Members are confidential and protected from disclosure under federal and/or State law

including, but not limited to, 42 U.S.C. §§ 290dd-2, New York Public Health Law Article 27-F, 10 N.Y.C.R.R Part 63, New York Mental Hygiene Law ("MHL") § 33.13 and/or 18 N.Y.C.R.R. Part 357, et seq.;

WHEREAS, the Compliance Monitors have requested access to Compliance Documents concerning Class Members and expect to do so in the future in furtherance of their duties under the Settlement;

WHEREAS, MHL § 33.13(c)(1) permits the disclosure of an individual's mental health and discharge planning records if the interests of justice significantly outweigh the need for confidentiality, and defendants believe that MHL §33.13(e) makes this provision applicable to facilities not operated by the State Office of Mental Health;

WHEREAS, defendants believe other federal and State confidentiality laws apply to the disclosure of Compliance Documents but that such laws permit the disclosure of Compliance Documents concerning Class Members pursuant to court order;

WHEREAS, the parties believe the interests of justice significantly outweigh the need for confidentiality of Class Members' records that may be covered by MHL § 33.13 so that the Compliance Monitors may have access to Class Members' records to which they are entitled under the Settlement so that they may perform their duties under the Settlement;

WHEREAS, 42 C.F.R. § 2.53(a) permits individuals who are performing auditing activities to review documents that contain substance abuse information, subject to the limitations set forth therein, and defendants believe that 42 C.F.R. § 2.53(a) is applicable to Compliance Documents;

WHEREAS, defendants acknowledge that the Compliance Monitors are performing audit activities within the meaning of 42 C.F.R. § 2.53(a);

WHEREAS, plaintiffs dispute the applicability of and the scope of the restrictions imposed by certain of the federal and State laws cited above;

WHEREAS, the parties have agreed to present this Stipulation and Interim Order to the Court for its approval in order to enable the Compliance Monitors to obtain access to many Compliance Documents, and have further agreed to present their remaining disputes to the Court for expedited resolution;

IT IS HEREBY ORDERED, that because the interests of justice significantly outweigh the need for confidentiality of Class Members' records that may be covered by MHL § 33.13, defendants shall make available to the Compliance Monitors such Compliance Documents concerning Class Members that may be covered by MHL § 33.13 as the Compliance Monitors may request and to which they are entitled under the Settlement;

IT IS HEREBY FURTHER ORDERED, that defendants shall make available to the Compliance Monitors on defendants' premises and subject to the re-disclosure provisions of 42 C.F.R. § 2.53, such Compliance Documents concerning Class Members that contain substance abuse information as the Compliance Monitors may request and to which they are entitled under the Settlement;

IT IS HEREBY FURTHER ORDERED, that nothing in this Order shall require defendants to disclose to the Compliance Monitors any HIV-related information concerning Class Members unless and until a further order is entered by the Court requiring such disclosure;

IT IS HEREBY FURTHER ORDERED, that defendants shall in all other respects comply with the terms of the Settlement including, but not limited to, the monitoring provisions of Section IV;

IT IS HEREBY FURTHER ORDERED, that nothing in this Order shall restrict defendants' ability under the Settlement to contest any request for records made by the

Compliance Monitors as being unreasonable or beyond the scope of their authority under the Settlement; and

IT IS HEREBY FURTHER ORDERED, that nothing in this Order shall be deemed to modify, reduce or in any way alter the obligations of the parties pursuant to the Settlement.

Dated: New York, New York
October 27, 2003

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Counsel for Defendants

SO ORDERED:

_____
J.S.C.

Exhibit B

Brad H Medication List

Medication			
Generic Name	**Trade Name**	**Class**	**Sub-class**
chlorpromazine	Thorazine	antipsychotic	first generation
fluphenazine	Prolixin	antipsychotic	first generation
fluphenazine decanoate	Prolixin decanoate	antipsychotic	first generation
haloperidol	Haldol	antipsychotic	first generation
haloperidol decanoate	Haldol decanoate	antipsychotic	first generation
loxapine	Loxitane	antipsychotic	first generation
mesoridazine	Serentil	antipsychotic	first generation
molindone	Moban	antipsychotic	first generation
perphenazine	Trilafon	antipsychotic	first generation
pimozide	Orap	antipsychotic	first generation
thioridazine	Mellaril	antipsychotic	first generation
thiothixene	Navane	antipsychotic	first generation
trifluoperazine	Stelazine	antipsychotic	first generation
aripiprazole	Abilify	antipsychotic	second generation
clozapine	Clozaril	antipsychotic	second generation
olanzapine	Zyprexa	antipsychotic	second generation
quetiapine	Seroquel	antipsychotic	second generation
risperidone	Risperdal	antipsychotic	second generation
ziprasidone	Geodon	antipsychotic	second generation
amitriptyline	Elavil, others	antidepressant	TCA
clomipramine	Anafranil	antidepressant	TCA
desipramine	Norpramin	antidepressant	TCA
doxepin	Sinequan	antidepressant	TCA
imipramine	Tofranil, others	antidepressant	TCA
nortriptyline	Pamelor, others	antidepressant	TCA
protriptyline	Vivactil	antidepressant	TCA
trimipramine	Surmontil	antidepressant	TCA
phenelzine	Nardil	antidepressant	MAOI
tranylcypromine	Parnate	antidepressant	MAOI
citalopram	Celexa	antidepressant	SSRI
escitalopram	Lexapro	antidepressant	SSRI
fluoxetine	Prozac, Sarafem	antidepressant	SSRI
fluvoxamine	Luvox	antidepressant	SSRI
paroxetine	Paxil	antidepressant	SSRI
sertraline	Zoloft	antidepressant	SSRI
amoxapine	Asendin	antidepressant	other
bupropion	Wellbutrin, Zyban	antidepressant	other
maprotiline	Ludiomil	antidepressant	other
mirtazapine	Remeron	antidepressant	other
nefazodone	Serzone	antidepressant	other
trazodone	Desyrel	antidepressant	other
venlafaxine	Effexor	antidepressant	other

Brad H Medication List

carbamazepine	Tegretol	mood stabilizer	anticonvulsant
divalproex sodium	Depakote	mood stabilizer	anticonvulsant
gabapentin	Neurontin	mood stabilizer	anticonvulsant
lamotrigine	Lamictal	mood stabilizer	anticonvulsant
oxcarbazapine	Trileptal	mood stabilizer	anticonvulsant
valproic acid	Depakene	mood stabilizer	anticonvulsant
lithium		mood stabilizer	other
NOTE: the term "class" indicates a naming convention for convenience only and does not imply that the medication indicated can only be used for that purpose. For example, carbamazepine is listed as an anticonvulsant and also for mood stabilization in bipolar disorder but can also be used for impulsive behavioral disorders. Citalopram is classed as an antidepressant but can also be used for anxiety disorders such as panic disorder, obsessive compulsive disorder and posttraumatic stress disorder.			