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.

SPECIAL REPORT OF THE COMPLIANCE MONITORS

November 17, 2003

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

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

Special Report of the Compliance Monitors

November 17, 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 §151 of the Stipulation, the Monitors may issue "interim reports... to address any issues... in response to a reasonable request for an update from either Class Counsel or Defendants' Counsel."

NOTE: Pursuant to ¶138 of the Stipulation, we are not identifying by name staff or employees of Defendant agencies in this report. Pursuant to ¶159 and the Confidentiality Agreement which we executed, we have protected the identity of the class member by using only his initial.

Introduction:

In a letter from Christopher Tahbaz dated October 10, 2003 (Exhibit A), the Monitors received a request to conduct an investigation and provide a written report of our findings related to the incarceration and post-release death of a detainee ("Mr. A.") recently released from the custody of the New York City Department of Corrections ("DOC") . This letter formalized a similar request made to us by electronic mail from Heather Barr on October 8. This was followed by a letter dated October 15, 2003 from Jeffrey Dantowitz concerning, *inter alia*, Defendants' view regarding the appropriate scope of the proposed investigation. (Exhibit B) After determining that, from the information we had available, Mr. A. appeared to have been a Class Member,[1] we decided to conduct such an investigation to determine the degree to which the Defendants adhered to their obligations to Mr. A. under the Stipulation in this matter, and, whether any aspects of the particular situation had systemic implications for the provision of discharge planning services to Class Members. On October 9 we requested Mr. A's entire medical record from Defendants. Eventually, at a status conference on October 14, the parties were able to draft an Order on consent for the production to the Monitors of most aspects of the requested medical records. (See Exhibit C), So Ordered by the Court on October 14). The records were made available to the Monitors for review on October 22 and October 23, and we thus commenced our investigation.

[1] Our subsequent investigation confirmed this belief and we consider Mr. A. to have been a Class Member under the Stipulation of Settlement.

Information used in this investigation was obtained from the following sources:

1. Medical Records[2] from jails in the New York DOC: the Vernon C. Bain Correctional Facility ("VCBC") and the Anna M. Kross Center ("AMKC").
2. Interview with the Mental Health Specialist who completed the Psycho-social evaluation and Discharge Service Needs (DSN) of Mr. A.
3. Medical Records from the Kings County Hospital Prison Ward ("KCPW").
4. Discussion with staff at the KCPW.
5. Interviews of discharge planning staff at Rikers Island and at the Community Referral Unit ("CRU").
6. CRU record and logbook.
7. Interviews of personnel from the Legal Aid Society, including attorneys and a paralegal.
8. Interviews of available family members of the decedent.
9. Class Counsel
10. Counsel for the defendants.

Chronology:

Mr. A. was arrested on He called a suicide hotline that morning, indicating that he was suicidal and had access to a gun. The suicide hotline staff contacted the police to send intervention. The police detained Mr. A., after entering the house where Mr. A. was staying and allegedly finding a gun. They took him to the emergency room of the Queens Hospital Center, where he was evaluated. He was then transferred to the KCPW and admitted on Admission diagnoses included recurrent major depression, substance induced mood disorder, cocaine and marijuana abuse, and rule out personality disorder not otherwise specified.

[2] For the purposes of this and future investigations and reviews, "medical records" shall be defined as all records pertaining to the medical and mental health needs of a Class Member.

Mr. A was arraigned at KCPW on . Legal Aid represented him and began working with him at this time. His attorney described him as depressed and crying frequently. However, his attorney also found him to be coherent, cogent and intelligent. She believed Mr. A. to be competent to stand trial. No competency evaluation was ordered.

Mr. A remained at KCPW until During this time, he was treated with Zoloft (an antidepressant), Depakote (a mood stabilizer and impulse control modulator) and Benadryl (for help sleeping). Staff at KCPW also provided support and psychotherapy. The records are ambiguous regarding stressors: in places the chart indicates that the suicide hotline call was prompted by a breakup with his girlfriend, and in other places it is noted that they broke up sometime during the hospitalization or incarceration. Still other reports indicate that she was pregnant. Finally, his attorney advised us that Mr. A.'s girlfriend was still an important part of his life and was working with his brother to arrange for bail and post-release housing. By the time of discharge from KCPW, Mr. A.'s axis IV diagnosis indicated only legal problems as a stressor and indicated that the severity of this stressor was "mild". There was no mention in his discharge summary of any family or relationship issues.

Mr. A. spent 18 days in the hospital, where he initially appeared very depressed, with crying spells and social withdrawal. By September 15, 2003, however, the severity of the depression was remitting, according to the KCPW record, and he

told staff that he was "ready to return to Rikers Island." On September 16, 2003, Mr. A's primary therapist documented a conversation with Legal Aid indicating that Legal Aid believed he would be released at a court date. In addition, the therapist in the hospital documented that she was advised by Mr. A's attorney that Legal Aid had "access to a social worker... that can set up outpatient treatment." Mr. A. was not transported to court on for reasons we have not been able to clearly determine. The hospital discharged Mr. A. late in the day, and he was transferred by the Department of Corrections to VCBC. Discharge diagnoses were adjustment disorder with depressed mood, polysubstance abuse (cocaine, crack, marijuana), and antisocial personality disorder.

The KCPW chart, in relevant part, indicates in the "Aftercare Support Plan" that Mr. A.'s living arrangement post discharge would be Rikers Island and that his treatment service needs were medication and psychotherapy. It is not clear to the Monitors whether the treatment needs section of this document reflected an assessment of his needs upon discharge from KCPW to the jail, or, alternatively, if he would be needing medication and psychotherapy in the community upon discharge from jail.

Upon arrival at VCBC, medical staff conducted an intake screening, which recognized Mr. A. as a potential suicide risk. The medical clinician referred him to the Mental Health Center at AMKC ("C-71") for a psychiatric evaluation at

about 2 A.M. on September 19, 2003. At C-71, the evaluating psychiatrist immediately admitted him to the Mental Health Center. Mr. A. was placed on Enhanced Suicide Observation ("ESO") immediately upon his assessment and remained on ESO until four days after his transfer from KCPW to VCBC and then to C-71. He remained at C-71 throughout the remainder of his incarceration. A variety of mental health staff saw him fairly regularly. The psychiatrist continued the medications that KCPW had started.

On September 22, 2003, a progress note written by one of the mental health staff at C-71 indicated that Mr. A said that he "hopes to get SSI and outpatient treatment." On Mr. A. appeared at a court date. At this time, his attorney indicated that he appeared to be much less depressed: still sad but not crying, and working very hard on his case. He advised his attorney that he believed he would make bail on that day, which ultimately did not happen.

The attorney indicated that she had requested consultation from a fellow attorney at Legal Aid with substantial expertise in mental health matters both on September and on September and that on the she was told that there were no further needs. The attorney had only a very limited understanding of the components of "discharge planning," and she seemingly took at face value her colleague's assurance that "it was taken care of". Of note is that CRU staff we interviewed told us that they believed that Legal Aid was taking care of making arrangements for mental health follow up, though they also said that, had they

received the chart in a timely manner, they would have done more for Mr. A even if Legal Aid was working with him. The CRU staff informed us that their prior experience was that Legal Aid requested discharge medications and aftercare letters in the context of a developed discharge plan for the client which included arranging for out-patient mental health services when required.[3]

On 2003 (day 6 of his Rikers Island incarceration, day 25 since his confinement in a secure DOC-monitored facility), a completed psychosocial assessment and comprehensive treatment and discharge plan (CTDP) were completed.[4] His diagnosis at that time was adjustment disorder with depressed mood, polysubstance dependence, and antisocial personality disorder. On the discharge service needs (DSN) form, the only recommendation was for "outpatient treatment". According to the mental health specialist who completed this form, she did not recommend MICA treatment because Mr. A. indicated to her that he would not participate in substance abuse treatment, she did not believe him to be homeless, and she recommended no entitlements. At this time, she also determined Mr. A. not to be Seriously and Persistently Mentally Ill

[3] Legal Aid apparently has a project which involves arranging for comprehensive discharge plans for certain clients who are have both substance abuse and mentally disabilities-related needs. The attorney consulted by Mr. A's attorney as well as the para-legal referenced in this report work for that program. Mr. A. was not an enrolled client in that specialized program, and the attorney who represented him is not associated with that program.

[4] We are aware that the staff at KCPW completed psychosocial assessments, psychiatric evaluations and treatment plans during Mr. A's hospitalization. However, although these documents and activities may have coincidentally met the required timelines under the Stipulation, we do not believe that the interventions were a "comprehensive treatment and discharge plan" as defined in the Stipulation's definition's section and elucidated in ¶¶16-17. Further, the discharge plan from KCPW was apparently "discharge to Rikers" and a vaguely stated "therapy and medication". While these plans may well have been clinically appropriate in terms of Mr.A's immediate care at Rikers Island, they seem to evince no view towards post-release planning.

("SPMI") under the New York State Office of Mental Health definition which was incorporated into the settlement of this cause.

For reasons not adequately explained, discharge planning staff did not receive the Discharge Service Needs form (DSN), until September 28, 2003 (a Sunday).[5] The DSN was logged into the discharge planning logbook on September 29, and the discharge planning supervisor assigned the case to a discharge planner that same day. Contrary to the discharge planning supervisor's assertion that discharge planners are expected to see the class member on the day of assignment, the discharge planner did not attempt to see Mr. A until September 30. She was unable to do so because of a "fight on the unit". She was able to see him on October 1, and began the process of having Mr. A. sign consent forms. In addition, she completed a Medicaid prescreening form. She did not make any efforts to obtain aftercare appointments or to contact Mr. A's attorney.

On a fax was sent from Legal Aid to the Discharge Planning CRU indicating that Mr. A would "hopefully" be released on and requesting discharge plans, medications, prescriptions and an aftercare letter. CRU staff advised us that they viewed this information as indicating that Mr. A. **would** be released and acted accordingly by faxing the information from the CRU to AMKC, where Mr. A was housed in C-71. CRU staff indicated that they expected this information to prompt the jail discharge planners to prioritize the case and

[5] CHS policy XI – C, Discharge Planning for Patients Receiving Mental Health Services, ¶A. 5. requires that the mental health clinician "shall immediately forward a copy of the Discharge Service Needs Form ... to the Document Control Caseworker in the facility."

forward the chart promptly to CRU for aftercare referrals, even if it would mean seeing Mr. A before his DSN was received. A confirmation was received indicating that the fax was sent successfully at 4:08 P.M. on that day. One of the jail discharge planners indicated that he received a follow up call regarding this fax on or about October 1, 2003. CRU staff told us that, although they did not document this follow up phone call, they routinely follow up such faxes with calls because "we know medication requests are most important." Discharge planning staff at AMKC told us that they did not receive this fax. They further reported that the fax was out of service on September 26, 2003 (and had been for 3 or 4 weeks prior to that date) and that this is why the fax was never received.[6]

We were able to interview one of the discharge planning staff members, in the presence of her union representative, who was involved in assisting Mr. A. close to the time of his release. She did not recall details of her involvement with his case. She explained that this was so because she has a caseload of 200 and a very high turnover rate among this caseload. She advised us that the routine practice at C71 is as follows: the mental health staff, upon completion of the CTDP, forward the DSN after co-signature by the mental health supervisor to the

[6] After circulating a draft of this report, we received the following information in an electronic mail communication from William Martin, General Counsel for DOHMH on November 14, 2003: "Repair calls for the fax were made on 9/15/03, 9/19, 10/2 and 10/8/03 to the company charged with servicing the machine, and repairs were made on 9/17, 9/24, and 10/9. Additionally, on 10/2, two new machines were ordered which were transported to Riker's Island on 10/16. Subsequent to the relevant time frames for the draft report, it was ascertained that the phone lines connected to the fax were the problem, and this was subsequently resolved." However, it is important to note that during our visit to AMKC on October 23, 2003, we had difficulty both sending and receiving faxes on a new fax machine that was apparently installed in an attempt to remedy the situation. Our opinion is that the operative issue—that the overall system is prone to difficulties of this type and thus is unreliable—should not be lost in an examination of details of this particular series of events.

Discharge Planning Supervisor. The Discharge Planning supervisor then assigns cases to the Discharge Planning staff. The discharge planner we interviewed, concurring with what the discharge planning supervisor told us, indicated that she tries to see her assigned cases the same day, but that sometimes due to a large number of referrals or the unavailability of the class member, she is unable to see the person that day. She believed that the policy allows for up to 3 days to see the referral.[7] Cases can be prioritized based on information received from other sources, such as the CRU. At times, such cases will be seen prior to receipt of the DSN.[8]

Relative to the dates in question in the instant case, this discharge planner indicated that she was aware that the fax machine was out of service sometime in September and October, but she was unable to specify how this problem related to his specific case. She did indicate that there are staffing problems that lead to delays in the formulation of a discharge plan. Finally, she informed us that the note she wrote on October 1, 2003 indicating that she gave Mr. A. the "Services in the Community" brochure means that she gave him this brochure (Exhibit D), and also two other pamphlets entitled "Discharge Planning Services For Brad H. Class members (Exhibit E) and Access to SPAN Offices for Brad H.

[7] CHS Policy XI – C, Discharge Planning for Patients Receiving Mental Health Services, ¶¶B. 7. and B. 8. indicate that the Document Control Caseworker should "immediately" notify the Client Contact Caseworker when a DSN is received, and that the Client Contact Caseworker, "Upon the above notification by the Document Control Caseworker, the Client Contact Caseworker shall interview the inmate."

[8] CHS Policy XI – C, Discharge Planning for Patients Receiving Mental Health Services, is silent on the issue of prioritized referrals for discharge planning based on the receipt of outside information.

Class Members (Exhibit F). All of these documents contain the contact information for the various SPAN Offices.

On Mr. A. appeared at court again, to testify before the Grand Jury. The Legal Aid paralegal advised us that he contacted the CRU at around 10 am and was told the medications had not yet been transported to the CRU from Rikers Island. He said that he called again at around 1 P.M. and was advised that the medicine had arrived. He said that he called for a third time at around 4 P.M. to notify the CRU that it did not appear that Mr. A. would be released that day. None of this is documented either at Legal Aid or at the CRU, and CRU staff did not recall these contacts. The Legal Aid staff member assigned to pick up the medications informed us that the process of obtaining these medications is very difficult and that Legal Aid would no longer support his doing this.

What happened after this is not entirely clear, but Mr. A. eventually was released. According to a log maintained by the Department of Corrections, forwarded to us by Defendant's Counsel, Mr. A. was logged out of the Queens courthouse sometime between 9:05 P.M. and 11:59 P.M. on [9] (Exhibit G) The circumstances of this release are not known to us, although it appears to us that the Grand Jury declined to indict him. On this same day, medications (and presumably, prescriptions, copies of which were in Mr. A's jail medical record)

[9] See redacted copy as Exhibit G. The black line indicates where the entries concerning Mr. A. are present.

were transported from the jail to the CRU in lower Manhattan. CRU notes indicate that CRU staff attempted to call the contact person at Legal Aid on and again on to arrange for these medications and prescriptions to be picked up and given to Mr. A. and that the calls were not returned until , after Mr. A's death.

According to Mr. A's attorney, he went to live with his girlfriend at his cousin's home in Queens upon his release during the evening of On October 6, he made two calls to his attorney, leaving voice mails both times. His attorney did not receive these messages until and told us that she did not have reason to believe from these messages that Mr. A. was depressed or suicidal when he left these messages. She called a cellular phone that she believed was Mr. A.'s girlfriend and was told that he had jumped in front of a train the evening before, after seeing his girlfriend off to work.

Findings and Recommendations:

1. Although not within our purview under this litigation, we must note our concern that an individual who contacts a suicide hotline to seek help for apparent depression would be arrested subsequent to this call.

2. At the time of Mr. A's release from the system, the following discharge planning tasks had been accomplished:
   - MGP card was available
   - Medications and prescriptions were available at the CRU
   - Medicaid prescreening application had been done and was returned by HRA to the jail, indicating that a new Medicaid application was needed

3. The staff at KCPW did not perform discharge planning. This had several ramifications or potential ramifications.

- The records indicate that there was a planned court date on , which was apparently unknown to DOC staff. The treatment providers at KCPW were clearly aware of this court date but DOC, for unknown reasons, did not produce Mr. A. to court. As a result, Mr. A. missed this court date and was sent, the same day, to VCBC. Had he been released at court on this day, the lack of discharge planning services would have resulted in his being released with no plan.

- In any event, the KCPW staff did not get involved in planning for community care. In fact, the discharge summary indicates that "Rikers Island" was the discharge plan. In part they may have been unintentionally misled by a communication with Legal Aid, who, according to the medical chart at KCPW, advised the clinical staff at KCPW that Legal Aid "has access to a social worker in her office that can set up outpatient treatment. She [the Legal Aid attorney] asked me to find out where he will be living so she can set up the treatment." The clinician at KCPW determined that Mr. A. would be living "in Manhattan with his friend" and so informed the attorney. It should be noted that upon interview, the attorney did not recall specific discussions with KCPW staff concerning plans for Mr. A.'s post-discharge treatment, although she did recall other aspects of these conversations.

Recommendation 1: **A determination must be made as to whether arrestees who, like Mr. A, are hospitalized immediately subsequent to arrest and before spending any time incarcerated in a non-hospital setting, are to be considered class members during their hospitalization.**[10] While this is likely to be a numerically small group of

[10] See Stipulation of Settlement at page 2, quoting the Court's certification of the Class in this cause as "all inmates (a) who are currently incarcerated or who will be incarcerated in a correctional facility operated by the New York City Department of Correction ("City Jail""), (b) whose period of confinement in City Jails lasts 24 hours or longer, and (c) who, during their confinement in City Jails, have received, are receiving, or will receive treatment for a mental illness; provided, however, that inmates who are seen by mental health staff on no more than two occasion during their confinement in any City Jail and are assessed on the latter of those occasions as having no need for further treatment in any City Jail or upon their release from any City Jail shall be excluded from the class."

Subsequent to our issuing a draft of this report, we discovered indications that DOHMH views the prison wards as DOC facilities for the purposes of identifying class members and providing them with discharge planning services. The DOHMH Database Collection Sheet is the mechanism by which discharge planners convey baseline demographic and clinical information to data entry personnel. The third field on this form asks the person completing the form to circle the *DOC* facility from a menu containing 15 choices. These choices include KCPW and EHPW (Elmhurst Hospital Prison Ward). For unclear reasons, this form does not indicate Bellevue Hospital Prison Ward. (Exhibit H; emphasis added)

Additionally, State Correction Law §2(16)(a) defines a correctional facility as "Any place operated by a county or the city of New York as a place for the confinement of persons ... charged with a crime and committed for trial or examination, awaiting the availability of a court,

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individuals, these individuals are clearly likely to be among the most severely ill and vulnerable and therefore most in need of coordinated care and release planning.

- If this group is determined to be class members, a mechanism must be developed to provide these class members with discharge planning services in accordance with the Stipulation, prior to any possible transfer to Rikers Island, which may or may not occur.
- If this group is not determined to fall within the Class definition, we recommend that communication links be developed between the hospital staff and the jail based discharge planners to attempt to provide coordinated release planning in a timely fashion.

4. There was a cumulative delay that, while not falling short of the time requirements required by the Stipulation, contributed to the ultimate discharge planning outcome, which is that there was no provision for Mr. A to receive ongoing mental health care upon his release. In addition, there are serious communication deficits among the multiple discharge planning units that contributed to the lack of an adequate, realized aftercare plan.
   - Mr. A was seen within 24 hours of his admission to VCBC for his medical screen and was immediately and appropriately referred for a psychiatric evaluation (¶14-15).
   - Mr. A had his comprehensive treatment and discharge plan ("CTDP") completed on September 25, 2003, before day 7 after his psychiatric evaluation, as required by ¶16 for Class Members housed on Mental Observation Units ("MOU"). At this time, pursuant to policy, a Discharge Service Needs ("DSN") was completed.
   - The DSN is the routine transmission of information from the mental health staff to the discharge planning staff in the jail. For reasons unclear to us, the DSN was not received by discharge planning staff for 3 days. The staff interviewed indicated that the DSN is not moved directly from mental health to discharge planning line staff, as CHS policy XI – C would seem to require, but; rather, it must be signed by a mental health supervisor first. It then goes to the discharge planning supervisor. Only then is the case assigned to a caseworker.
   - Communication from Legal Aid, which should have prompted an expedited response by discharge planning staff, was not effectively transmitted to the jail discharge planning staff in a timely way.
   - There is some question about communication between Legal Aid and the CRU. Some at Legal Aid believe that this communication

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duly committed for contempt or upon civil process, convicted of any offense and sentenced to imprisonment therein or awaiting transportation under sentence to imprisonment in a correctional facility, or pursuant to any other applicable provisions of law." (See Exhibit I) We find the forgoing persuasive that the prison wards, including KCPW, are correctional facilities according to State Law and are considered as such in DOHMH's practice.

occurred earlier than (the date of the first documented contact). All agree that Legal Aid informed CRU on that Mr. A. was likely to be released on

i. According to CRU staff, they did not hear back from Legal Aid but received and held medication on CRU's records indicate that they contacted Legal Aid on and again on leaving messages both times. Only on , after Mr. A's death, did Legal Aid return calls to CRU, according to their records.

ii. According to Legal Aid, however, Legal Aid staff was in frequent phone contact with CRU on contacting them first at 10:00 A.M. to find out that Mr. A.'s medications had not yet arrived. Legal Aid called again at around 1:00 P.M. and was told that the medications were there for him. At about 4:00 pm, Legal Aid, determined that Mr. A. was not likely to be released after all, and called CRU to advise them of this and to inform them that he would not be picking up the medication. They reportedly told him that they would hold the medicine for a few days "just in case."

It is clear that the time limits outlined in the Stipulation constitute a minimum standard, as there will be many class members for whom Defendants may be considered to have won the battle (i.e. met the deadlines) but lost the war (i.e. not developed an adequate discharge plan prior to release). One staff member we interviewed phrased it thus: "we are meeting the letter but not the spirit of the law." Mr. A is one of these cases in which procedural requirements were met but no discharge plan resulted.[11] Ultimately, there appear to be two major, serious deficits in the system as defined presently:

- **There is no single point of responsibility for discharge planning.** This theme resonated throughout all of our interviews and reviews. Such diffusion of responsibility was evident
  - Within the mental health service, where a class member might see multiple providers rather than having a single, identified, primary therapist
  - Within the multiple discharge planning units, in which different tasks are delegated to specific, discrete personnel as if they were isolated or could be dealt with in a vacuum

[11] The statement that procedural requirements were met refers only to the time-lines contained in the Stipulation, and ***is only so if the triggering event is considered to be admission to a New York City jail, and does not include the three prison wards*** (see Recommendation 1, above). These units are based in New York City Health and Hospitals ("HHC") facilities and the treatment provided is under HHC control. However, for security purposes, these units are controlled by the New York City Department of Corrections ("DOC"). In this respect, the arrangement is not unlike Rikers Island facilities where security control is maintained by DOC as the same time treatment is provided by a distinct entity. If the "clock" is not tolled for direct admission to a hospital prison ward, the Defendants as a group did not comply with the timelines.

- Between discharge planning and mental health, with variable communication and coordination
- Between the prison wards and the jails

- **There is inadequate and unreliable communication between staff responsible for discharge planning services.**

Recommendation 2:

Discharge planning with this population which has multiple needs and very rapid turnover is a difficult and complex task. Class members are transferred among facilities and are often precipitously and unexpectedly released. Because of the complexity and difficulty involved, discharge planning is very unforgiving of inefficiencies in the operationalizing of the task. Seemingly minor delays in achieving steps in the process accumulate to produce an overall delay that is unacceptable. The system as currently configured by Defendants must be simplified.

We strongly recommend that Defendants completely restructure the discharge planning staff model as well as the overall service-delivery model, move all discharge planners to the jails, hire as many clinically trained discharge planners as possible. We are aware of plans by the Department of Health/Department of Mental Hygiene to accomplish this goal, and strongly urge that these plans be expedited. This system appears to be able to promise a higher level of responsibility and accountability for discharge planning. The new system should be implemented without delay.

Recommendation 3: **Communication must be improved.**[12]
Even if recommendation 2 were implemented immediately, it will likely be insufficient if lines of communication are not improved and made much more reliable. It is unacceptable for a fax machine to be down for 3 or 4 weeks if this fax machine is the only mechanism for communication of vital information. Steps should be taken immediately to provide all discharge planners with highly reliable electronic communication networks (such as voice mail and email) so that information flows efficiently and quickly.

There must be improved coordination between the mental health providers and the discharge planners. Compliance with many aspects of the Stipulation, as with sound discharge planning in general, requires a reliable, bidirectional flow of information as well as case conferencing among staff performing these functions. Different models exist for integrating these inextricably bound services. The potential for

[12] Paragraph 11 of the Stipulation states in relevant part: "Defendants shall also ensure that each such message [left by an individual contacting the CRU]is promptly relayed to other Discharge Planning Staff as appropriate."

discontinuity between clinical and discharge planning services is increased by the current system which dichotomizes these two tasks between different staff working for distinct organizations.[13] Under such circumstances, communication of information as well as meaningful, regular case discussions are essential. We suggest that a sound start would be for DOHMH to require the contractor for mental health services to conduct regular case conferences concerning Class Members on Mental Observation units which include discharge planners in relevant areas and cases. This would promote the crucial exchange of information about Class Members' post-release needs.

5. Some treatment staff and defense counsel which whom we have spoken are unaware of the nature and scope of the *Brad H.* litigation and of the remedies provided in the Stipulation. A primary example of this is the reports we received from mental health staff and from Legal Aid, as well a number of Class Members, that they did not know what SPAN is.

   Recommendation 4: **We strongly recommend that Defendants educate all providers within the Jails, and offer education to Defense Counsel, regarding this litigation and the various remedies involved. This will allow these line clinical and legal personnel, who have contact with all or most Class Members, to educate Class Members regarding the litigation, their rights to discharge planning, and what sorts of services are available to them.** While the knowledge regarding SPAN is the most obvious deficit in this case, we believe that the Stipulation as a whole should be part of this educational effort. We point out that conceptually, SPAN is meant to be available for Class Members who are released from jail before a comprehensive discharge plan is developed or implemented. Clearly, SPAN can only function in this role to the extent that staff and inmates are realistically informed of SPAN's role.

6. There is inadequate understanding and communication of the role of SPAN among staff and Class Members. While discharge planning staff appear to be giving inmates brochures and pamphlets, thus meeting the letter of the Stipulation, many of the inmates we have spoken with report that they have never heard the terms "SPAN" or "SPAN office". We fully support the efforts of SPAN staff to perform the mandated in-reach visits in the jails, but urge DOH/DM to require SPAN to augment this mandatory effort. We do not believe that this is enough.

   Recommendation 5: Education about SPAN must be improved. We suggest the following:
   - **All mental health and discharge planning staff should be provided with information about SPAN, the role of SPAN in**

[13] We acknowledge that DOHMH, which provides directly the discharge planning services, also has oversight responsibility of the contracted provider of mental health services on Rikers Island.

picking up on discharge needs that have not been met by the jail based discharge planners, and the location of the SPAN offices. This would allow them to better explain the services provided to inmates they are working with. This approach would, in our opinion, reach a greater number of Class Members than the valuable, required in-reach programs.

- As noted above in Recommendation 4, **outside agents and agencies who are involved with class members should receive information and education about SPAN.**
- **Posters describing the SPAN offices should be posted in prominent places in the clinic and mental health housing areas in effort to reach as many class members as possible.**[14]

7. Class members leaving from court have no reasonable way to get their walking medications or prescriptions. At this time, walking medications, prescriptions and an aftercare letter are delivered via driver to the CRU in lower Manhattan. This is not acceptable, for the following reasons:
    - Most class members will not find this to be a convenient place to go on the first day after their release. It is a long distance from all but the Manhattan court houses, and the CRU will likely be closed by the time a class member is processed out of court and can make his/her way to the CRU
    - The CRU is very difficult to get into: when we interviewed the CRU staff, we were forced to have them come out of the building as we would have been waiting in line for more than an hour just to get through the security checkpoint to get into the building. Class members and their community providers should not have to spend this amount of time to get their medications.

    Recommendation 6: A better mechanism must be developed to get medications to class members released at court. We suggest that defendants consider the following options:
    - Use of the SPAN offices for this task, in a way similar to how the CRU currently functions.
    - Development of a contract or agreement between Defendants and community pharmacies in each borough where class members can receive medications.

8. Mr. A. had inadequate assessment of his status as seriously and persistently mentally ill ("SPMI") as required by ¶24ff.
    - There was no evidence that he had a "likely SPMI" assessment at the time of his initial assessment during his psychiatric evaluation early in the morning of September 19 (¶24). The Monitors were

[14] In fact, this approach was suggested to us by a Class Member we interviewed recently on Rikers Island. After we explained to this person the services SPAN could provided, the visibly pleased Class Member said: "They should have posters about this all around the clinic."

unable to locate the "likely SPMI" form in the medical record in the jail.

- Given that Mr. A. arrived from a hospital and was taking medication, he was appropriately seen rapidly by mental health staff and nearly immediately transferred to the AMKC Mental Observation Unit ("MOU"). He was continued on his medications. These medications where clearly prescribed to treatment a diagnosable mental health condition and appear on the list of medications sent to the defendants on September 7, 2003 pursuant to paragraph 27 of the Stipulation. This alone should have made him "likely SPMI."
- At the time of Mr. A's CTDP, on September 25, 2003, he was indicated by a checkbox on the Discharge Service Needs (DSN) form to be not SPMI. This finding is difficult for the monitors to understand, given the totality of his case, which included
    i. The diagnosis of a mood disorder variably characterized as major depression and adjustment disorder with depressed mood (both of which meet the diagnosis criteria of the NY State Office of Mental Health SPMI definition)
    ii. A ninety- minute suicide hotline call, which prompted police intervention and led directly to an eighteen- day psychiatric hospitalization. This fact alone should prompt significant questions regarding Mr. A's level of functioning immediately prior to his incarceration.

Our discussion with the clinician who determined Mr. A to be not SPMI indicated a deficit in her understanding of the SPMI definition; this caused her to interpret SPMI in a much more narrow way than the definition allows. While this is just one person, her understanding of SPMI reflects what we believe to be a common misperception among clinicians (including ourselves prior to entering into our current role in this litigation). This can only be addressed through the systematic, detailed training of mental health staff.

Absence of the SPMI form in Mr. A's chart (which is consistent with the absence of this form in 7 of the 16 charts – 44% - which we have randomly reviewed) is unacceptable, because of the centrality of the SPMI assessment for certain services. (Given the overall deficits in discharge planning outlined above, we are not convinced that a proper SPMI determination would have led to improved discharge plans for Mr. A.) This issue will be the subject of intensive and ongoing monitoring.

Recommendation 7: We are aware that DOH/DMH developed and has scheduled training on the SPMI evaluation and on the discharge planning services available to class members who are SPMI. We were involved in the review of the training materials to be used by DOH/DMH and believe that they should be useful in this regard. **Training on the SPMI definition and use of the evaluation tool must begin without delay. This training must include both discharge planning and mental health staff. It should be followed by periodic in-service training and should be monitored via a DOHMH performance improvement indicator.**

Conclusions:

There were a number of deficits the discharge planning provided to this Class Member.

A series of recommendations include:

- The 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
- The development of single points of responsibility for the mental health care and the discharge planning for each class member
- Hastening of the reorganization of the discharge planning staff as planned by DOH/DMH
- Improved communication and communication technology
- Educational efforts regarding the litigation, the stipulation and the remedies under this case for line clinical and legal staff
- Systematic training of all relevant staff regarding the requirements of the Stipulation, such as the SPMI evaluation, and the role of the SPAN offices.
- Develop a better mechanism to get medications to court-released class members

Respectfully submitted,

Henry Dlugacz
Compliance Monitor

Erik Roskes
Compliance Monitor

STATE OF NEW YORK, COUNTY OF NEW YORK ss.:

I, HENRY A. DLUGACZ, being duly sworn, say, depose, and affirm: I am over 18 years of age and maintain a full-time office located at 740 Broadway, 5th floor, New York, N.Y. 10003. I am an attorney licensed to practice law before the Courts of the State of New York.

On November 17, 2003, I served the parties named below with the SPECIAL REPORT OF THE COMPLIANCE MONITORS by causing to be deposited a true copy thereof enclosed in a post-paid wrapper in an official depository under the exclusive care and custody of the United States Postal Service within New York State, addressed to each of the following persons at the last known address set forth after each name:

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Affirmed this 17th day of November, 2003

HENRY A. DLUGACZ