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.	:	

Fourth Quarterly Report of the Compliance Monitors
June 7, 2004

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 90 days during the first year following the Implementation Date. This constitutes the Fourth Quarterly Report of the Monitors.

CONTENTS:

I. REVIEW OF PRIOR REPORT RECOMENDATIONS

Our over-arching observation is that the Department of Health and Mental Hygiene (DOHMH), has implemented or is in the process of implementing a number of structural changes which are designed to create the context for the improvement of actual performance. While we recognize and strongly support these changes, we qualify this statement of support for the direction in which DOHMH is moving in two significant ways: (1) some of the important changes have yet to be implemented fully; and (2) they have not at this time yet yielded demonstrable improvement in compliance "on the ground." Examples of positive changes and of areas in which little change has been observed will be detailed below.

We will begin this report with a review of recommendations made in our prior reports regarding a variety of deficiencies in Defendants' compliance with the requirements of the Stipulation. At times, upon identifying a specific deficiency, we have made recommendations as to how they might be remedied.

In all cases, we have put forth these recommendations (1) to offer guidance, and (2) in the hope that they would engender both intra and inter-party discussions on what we view as important issues related to goals, requirements and obligations contained in the Stipulation.

The chart in Appendix 1 summarizes recommendations we made previously. Please note that while most of the recommendations counsel action on the part of Defendants, some require bi-lateral work by the Parties.

Important improvements which have occurred since the time of our Third Report include the introduction of voice mail for use by discharge planners in the jails, the implementation of regular case conferences between mental health and discharge planning staff, the implementation of email access (albeit at a central site on Rikers Island rather than at the point of service where it would be most useful), ongoing upgrades in data collection and reporting capacity, and the ongoing recruitment for and retention of masters-prepared discharge planners.

The recommendation table in Appendix 1 makes clear that Defendants have yet to fully address the issues which underlie our recommendations. In our opinion, the most important of these include:[1] the consolidation of the four separated discharge planning tasks (recommendation 3)[2], the provision of discharge planning services to Class Members hospitalized on the prison wards (recommendations 8 and 9), real-time access to medical records and discharge planning records, both paper and

[1] This list should not be read to indicate that the other recommendations we have made should not be addressed or that we will not monitor progress in those areas.

[2] This is not technically our recommendation: Defendants first presented the plan for this consolidation to us at a meeting on July 18, 2003. Our characterization of it at this point as a recommendation relates to the delayed implementation of this plan for consolidation. Our response to the proposed change, as stated in our First Quarterly Report, was as follows: "In our opinion, the philosophy behind this change is sound and we support its implementation. If the plan is properly realized, a more efficient and integrated service delivery system for discharge planning services should result. We believe that the long term improvements in efficiency of service delivery and in accountability will more than make up for the short term disruption this system change will bring." We used similar language in our Second Quarterly Report (see pp. 14-15). Again, we supported this change in our Third Quarterly Report (see pp. 59-62). We urge the Defendants to complete the implementation of this change as quickly as possible.

electronic (recommendations 10, 12, and 13), and further improvement of data collection and the MIS system (recommendation 15).

Our draft version of Appendix 1 contained an additional column outlining our view of the nature of these recommendations as mandatory versus consultative/suggestive. Defendants objected to this characterization, noting that they are not obliged to follow or comply with our recommendations. We agree that, at this point, Defendants are free to address the underlying issues identified in any way they see fit, and as a result we have removed this distinction. However, we believe that our suggested solutions represent the easiest, quickest, most expeditious or most comprehensive solutions to the problems we have identified. We note as well that some of our "recommendations" more properly are characterized as requests or requirements on our part for Defendants' assistance in our monitoring. Examples of these include most notably recommendations regarding data capture and reporting.

We also changed the draft column labeled "Remedial Actions Taken to Date" to "Status". We request that Defendants use the Table that is Appendix 1 to formally provide feedback to us regarding their actions in response to our recommendations.

II. PROCESS

a. Activities of the Monitors

During this reporting period, we continued to review records and interview Class Members confined in the New York City Department of Correction ("DOC"), as well as those receiving services at a SPAN office. As a part of this effort, we began to develop our own database for use in tracking and analyzing the cases we reviewed.

We spent a significant amount of time working with Defendants on the following issues:

- the findings contained in our reports
- our requests for data in a timely and reliable way
- Defendants' response to the Court's ruling on confidentiality, and their development of procedures for providing us with requisite access consistent with that ruling
- Defendants' development of a reliable and mutually understood data collection and reporting system for our use
- our request for assistance from Defendants regarding the development of our own monitoring database
- a budget modification regarding statistical support
- a budget proposal for the next fiscal year

In addition, we began holding regular oversight/informational meetings with Deputy Commissioner James Capoziello, the Director of the Division of Health Care Access (HCIA) and Improvement of DOHMH and his staff. After reorganization, HCIA has become the entity within DOHMH with oversight of both the mental health care and the discharge planning services provided pursuant to the Stipulation. We continued meeting with Plaintiffs' counsel as well.

b. Confidentiality and Access to Records

The Stipulation of Settlement of this cause of action provides at ¶120 that we shall have access to all documents and records that are reasonably necessary in our judgment to determine compliance. Mental Health Records and medical records related to mental health treatment and discharge-planning services are specifically included within the ambit our review and access authority. The issue arose as to whether the New York State Mental Hygiene Law (MHL section 33.13), the New York State Public Health Laws (Section 2782 (1)), and Federal regulations related to the confidentiality of certain substance abuse information (42 CFR 2.53 (a) 1(1) and 42 CFR 2.53 [b]), limited or

precluded our ability to lawfully review and/or copy information purported to fall within confidentiality protections afforded recipients of medical, mental health and or substance treatment under these various statutes and regulations.

The issue was the subject of stipulations by the Parties, briefing to the Court, and a conference with Justice Braun's Law Secretary. On March 22, 2004, the Court issued an Opinion regarding this issue. (See Appendix 2.) In that decision, the Court held that:

- " . . . neither the compliance monitors nor plaintiffs' counsel fall under 42 CFR 2.53 (a) (1). Thus, neither has the right to obtain photocopies of any such [substance abuse] information (see 42 CRF 2.53 [b])." (Justice Braun's Opinion at pages 2-3)
- "Public Health Law § 2782 (1) makes confidential HIV related information (*citations omitted*). Neither the compliance monitors nor class counsel fall under the exceptions thereunder to permit disclosure to them of such [HIV-related] confidential information." (Justice Braun's Opinion at page 3)
- "The parties have expressly stipulated * * * that Mental Hygiene Law § 33.13 applies to certain mental health records regarding plaintiffs. If it does, the interest of justice outweighs the need for confidentiality of plaintiffs' mental health records, pursuant to Mental Hygiene Law § 33.13 (c) (1)" (*citations omitted*.) (Justice Braun's Opinion at page 3)

Following careful review and consultation with the Parties, we believe the Court's Opinion places the following potential practical limitations upon our access to records:

1. We may *not copy, but may review,* protected substance abuse information without either (a) a release from the person whose protected substance abuse information is to be copied, or (b) appropriate redactions of said protected information.
2. We may *not review* HIV-related information, as defined in The New York State HIV/Confidentiality Law[3], in the absence of either: (a) a release from the person whose HIV-related information is to be reviewed, or (b) the appropriate redactions of said protected information.

Thus fell to the Monitors and the Parties the task of reconciling our mandate to monitor compliance as So Ordered in the Stipulation of Settlement, with the limitations placed upon those efforts by the various state and federal confidentiality laws as applied to our role by the Court.

We promptly conferred with both Parties as to their respective understandings of the Court's Order and Opinion resolving this issue, and arranged discussions and meetings with the appropriate Defendants and their counsel in an attempt to create a mechanism which, consistent with Justice Braun's Opinion, can provide us with the prompt and accurate access to records we require to perform our duties completely, fairly, and with integrity.

Two primary approaches have been outlined as potential solutions:

1. Obtain signed releases from Class Members to review (HIV), and/or copy (Substance Abuse) protected information, as the case may be.

[3] "New York State Consolidated Laws, Public Health, Article 27F (HIV and AIDS Related Information), §2782 (Confidentiality and Disclosure)"

2. Have Defendants redact protected information from the records we wish to review.

Taken alone, these approaches carry substantial operational and substantive difficulties. If we were to attempt to obtain signed releases from each and every Class Member whose record we wished to review, we would encounter the following problems:

1. Our reviews would be limited entirely to active records of Class Members currently confined in the New York City jail system, who are available on a given day;
2. Our reviews would be artificially limited in number[4] because of the time involved in awaiting production and interviewing of Class Members in order to obtain consent;
3. Our reviews would *per se* exclude any Class Member who refused to give consent and/or to come to a specific area to complete this process[5];
4. This approach would place a operational burden on both DOHMH and DOC which we wish to avoid if at all reasonably possible;
5. We considered and discussed asking DOHMH or its contractor to attempt to obtain consents for release of HIV information from Class Members (or potential Class Members) at the time that HIV- testing and/or treatment was offered, but accept the City's assertion that such an approach might reduce compliance rates

[4] This is apart from the on-going discussion we are having with DOHMH regarding appropriate sample size.

[5] This raises the significant issue of bias. Should we be able to review records **only** related to Class Members who consent to our doing so, our sample will by definition exclude many Class Members who do not so consent. Thus, our sample will appear markedly different from the population as a whole, which includes a substantial number of "refusers" (see below). We do not believe that such a biased sample permits complete monitoring.

with such offered testing or treatment, a result we clearly wish to attempt to avoid from a public health viewpoint.

Redaction of records also presents problems. This approach would entail a considerable waiting period between the time we request charts and the time they are produced. This would be inefficient, and make it exceedingly difficult to measure compliance with specific obligations as of a date certain. Additionally, we believe that any considerable lag between our request and the production of records for review on an on-going basis may reduce the perceived integrity of our monitoring functions.

As an interim procedure, we have requested signed releases from all Class Members whose chart we wish to review. We have done so to ensure that our on-site monitoring capacity did not cease entirely pending resolution of this issue. For the reasons already described, we do not see this as a viable, long-term solution.

While not entirely satisfactory to us, our latest attempt to reconcile all of the competing interests and factors above, led us on May 4, 2004 to forward the following proposal, via email, to Defendants in an attempt to further discussions and resolve this matter for the balance of the monitoring period. We are eagerly awaiting a response. We proposed:

1. At the time Class Members first meet with Discharge Planners they are asked to sign a number of consent forms. At this time, they would be offered the opportunity to sign a release which would grant the Monitors and our staff access to their HIV and Substance Abuse records for monitoring purposes. This "de-links" the request for consent from the counseling regarding testing.

2. At the time we make a request for records, a member of the clerical staff in the facility would check as to whether a signed consent (as per above) is present in the record. In the event that such a signed consent form is located, we would be granted immediate, unfettered access to the record. In cases where such a signed consent is not present, we would ask that DOC escort the Class Member to a location where we could interview him or her. During the process of this interview (which would be useful for a variety of collateral reasons) we would give the Class Member the opportunity to grant us written permission to review his or her protected information. In the event that the Class Member signed such consent, we would notify the staff at the facility, and the record would be made available to us at that time.
3. In the event that the Class Member either declined to speak with us and/or to sign a consent, we would not be granted immediate access to the record, but, rather would place the Class Member's name and book and case number on a list to be submitted for review by DOHMH or its contractor, and if needed, a timely redaction procedure. We would then be afforded timely (but not immediate) access to a cleared or redacted record as the case may be. This record would be provided for our review in a jointly agreed upon place and manner, accompanied by a certification by someone with appropriate authority indicating that it is a true and complete copy of the record as of a date certain.
4. For closed records, we would utilize the same procedure, by-passing the procedure delineated in number 2 above.

c. Access to Social Security Benefits, Veterans' Benefits and Food Stamps

Paragraph 87 of the Stipulation requires Defendants to "explore the feasibility of a system for the assessment of Class Members' eligibility for SSI, SSD, other Social Security Benefits and Veterans Administration Benefits, and the completion and submission of applications for such benefits on behalf of Class Members before their Release Date, and Defendants shall implement a system to assist Class Members in obtaining such benefits, if such a system is feasible. Defendants shall confer with the Compliance Monitors at least every six months regarding their efforts to implement such a system." On November 24, 2003, we received an initial response regarding our request for an update regarding Defendants' progress on this issue and were advised that Defendants were focusing on developing policies and procedures regarding the discharge planning activities pursuant to the Stipulation. In our Third Quarterly Report we indicated that Defendants had conducted a meeting with representatives from the Social Security Administration ("SSA") on February 9, 2004 to explore the feasibility of submitting SSI/SSD applications for Class Members incarcerated in the New York City Correctional system. Defendants indicated that they discussed several options at this meeting which required additional exploration before a determination of whether they would be viable given the requirements and procedures required by the Social Security Administration. Defendants now report to us as follows:

"After meeting with representatives of the Social Security Administration (SSA) on February 9, staff from the Mayor's Office has been in steady contact with SSA staff to more fully understand the categories of potential SSI beneficiaries and the parameters for

restoration/provision of SSI benefits. In short, we have learned that there are three groups of potential beneficiaries in the prison population and for each group there are distinct regulations and processes that pertain to the restoration or provision of benefits:"

i. beneficiaries who have received SSI and have had their benefits suspended for less than a year can have those benefits restored upon a redetermination finding by SSA that the beneficiary remains entitled to the benefit,
ii. beneficiaries who received SSI in the past and have had their benefits suspended for more than a year are treated as new applicants requiring the submission of a full application for benefits, and
iii. potential beneficiaries who may meet the eligibility criteria to apply for SSI benefits and will require a full application for benefits

DOC "receives information on a monthly basis, through a data-sharing agreement with the SSA, about inmates who are receiving SSI so that their benefits can be suspended by SSA during their period of incarceration. Our work in upcoming weeks will be focused on examining potential data sharing protocols between and among city agencies and SSA to determine feasible ways to identify those Brad H SPMI inmates who have had SSI in the past and develop processes with the SSA, particularly for those inmates with known release dates, to assist them in restoring their benefits upon release. We also will work with SSA on assessing the alignment of DOHMH clinical assessment and treatment forms and the elements of the SSI application to determine how and whether discharge planning staff can prepare and submit an SSI application, building upon existing data and information in DOHMH's control at Rikers Island."

We note at this point that there appears to be some progress on this important discharge planning and community transition issue. The information provided to date does not indicate if the SSA representatives with whom the City have been working have a sufficient level of authority to implement the required changes. The City has not made clear to us the nature and extent of any obstacles to the provision of Social Security benefits to eligible Class Members, or any proposals for overcoming them.

In addition, unrelated to our involvement in this case, we are aware that the New York State Department of Corrections and the Federal government instituted arrangements similar to those contemplated in this Stipulation to provide for greater continuity of benefits and a more efficient benefits application process for inmates released from state custody. This would suggest to us that there already exists an analogous practice within the Region 2 of the Social Security Administration with oversight of this issue from the Federal perspective. We fully understand that significant operational differences exist between the creation of such arrangements for the transient, detainee population of a large urban jail and so doing for a more static state prison population, but nonetheless we are not convinced that with more sustained efforts favorable results could not obtain in this area. This is particularly but not exclusively so for eligible Class Members serving determinate sentences.

Defendants also reported: “We are also working the Veteran's Administration to define the types of benefits--compensation, education and pension--that are available to inmates who are veterans both during and after incarceration. At present, while the intake process for inmates at the Department of Corrections seeks self-reporting on an inmate's military service, that information is not formally tracked in the DOC IIS

database. Our first step in determining how best to connect SPMI inmates to veteran's benefits for which they may qualify is to have a system to identify such inmates through the DOC IIS system and have that information available to the discharge planners. We are now working with DOC to assess how military service information can be included in the IIS database." We will continue to monitor progress on this important area.

In our Second Quarterly Report, we summarized a series of correspondence between Commissioner Eggleston of HRA and the USDA regarding applications for food stamps prior to release for Class Members who are SPMI. We concluded that Defendants would continue to pursue this issue, as required in ¶86. To date, we are unaware of any further movement on this issue, and request of Defendants an update on this topic. We recommend that Defendants continue to pursue this as required.

Upon full consideration of the material submitted to us for review, we are not yet prepared to find that Defendants have put forth the best efforts required by ¶¶86-87. We would be pleased to offer our assistance in working with the City and the Federal government on these efforts, and would be willing to attend meetings, act as liaison, and/or offer suggestions. At this time, although we support the fact that stalled efforts have begun, we do not find the City to be in compliance with ¶87.

d. Time of Release (¶32)

The Stipulation, at ¶32, provides that Defendants are to release Class Members only during daylight hours, and in no event earlier than 8:00 a.m. The exceptions to this requirement are (a) Class Members released from incarceration on bail or pursuant to court order requiring immediate release, or (b) those released directly from a courthouse. Over an extended period of time, we requested of Defendants: (a) clarification as to how

the Department of Corrections operationalizes the term "daylight hours"; (b) how Defendants interpret the word "released" (i.e., does it connote official release from detainer, or actual physical release from the facility?); and, (c) for data regarding compliance with this requirement. To date, we have received no compliance data.

We did, however, recently receive DOC Operations Order 03/03, which makes clear how DOC operationalizes the daylight hours release requirement. This Order provides in section III C 1 that "Inmates with this indicator [M indicating in need of mental health discharge planning] will be discharged between 0800 hours and 1600 hours only, unless bailed out, or released pursuant to court order requiring immediate release." In our view, this language defines a procedure which, if followed, would meet the requirements of ¶32 of the Stipulation.

We also received a preliminary response from Defendants' Counsel indicating that the time of release entered into the Inmate Information System ("IIS") corresponds to "the time the inmate is released from jail, not the time the commitment is lifted." Counsel is working presently to confirm this information. We do not imply that we accept as an equitable definition of the term release as anything other than release from actual custody. Any other interpretation would, in our view, thwart what appears to us to be the intent of this provision. Having said that, we remain, as always, receptive to input from the Parties, and, of course, direction from the Court.

Defendants also indicated continued difficulty in the reporting of actual data regarding time of release. They cited several reasons for this. These reasons include:

"(i) the inability to distinguish on IIS between those Class Members whose release date is known in advance, and those who are sentenced at court to time-served, both of which get indicated in IIS as "sentenced";

"(ii) the inability -- by the time the report is due -- to review all the files of those sentenced Class Members who appear to be released "late" (however that is defined), to determine which category they fall into, and to determine from a file review if the person actually was released late or whether the time indicated in IIS is time of data entry (as is sometimes the case), or the actual time of discharge; and

"(iii) DOC's present inability to know which Class Members were designated as Class Members during this reporting period."

Regarding item (i), we strongly encourage Defendants to determine a way to sort out these two groups of Class Members, as Defendants' obligations to the first group (those with release dates known in advance) are very different from their obligations to the second group (those who are released with "time served"). These obligations include not only time of release but also the requirement to provide Class Members in the first group with appointments rather than referrals.[6]

[6] Defendants, in their detailed responses to our draft report, point out they are not obligated by the Stipulation per se to distinguish between these groups ({a} those for whom sentences and thus release dates are known in advance as opposed to {b} those who appear in court and are at that time sentenced to "time served", thus depriving Defendants of the advance notice of release date which seeing a sentence and expiration date upon retrospective review would seem to indicate). They further note that the need to separate these two groups relates to our ability to monitor discharge planning services rather than directly to the provision of such services. Further, they assert that sentence date is "not synonymous with 'known release' date". It appeared to us reasonable and consistent with the Stipulation to consider in our monitoring the distinction drawn between Class Members for whom discharge planners had or should have had actual notice of a pending release date versus those for whom this only appeared in retrospect to be the case. We noted this in our draft report. As a result, we requested that Defendants acquire the ability to separate these groups. It strikes us then as somewhat circular reasoning to assert that it is improper for us

Regarding item (ii), we use this opportunity to request of Defendants that they prepare the necessary mechanisms for having this data available for our next report. Regarding item (iii), we will deal with this particular issue below in section III.i. "State of Data Reporting."

Finally, Defendants reported the results of a pilot survey of time of release, conducted between December 15 and December 20, 2003, at Eric M. Taylor Center ("EMTC") and Rose M. Singer Center ("RMSC"). Defendants chose these two facilities as they house "the vast majority of sentenced inmates." Defendants' findings were that

- 100% of 56 Class Members released from RMSC were released within the required time window.
- 91% (30 of 33) Class Members released from EMTC were released within the appropriate time frame. A memo was circulated to all "facility Tour Commanders and Intake Captains to reiterate and reinforce the requirements of Operations Order 03/03."

Assuming that the meaning of "release" is as defined above, we believe this pilot indicates a high overall level of compliance with ¶32. We look forward to seeing system-wide data for our next report. In the interim, we suggest reviewing this requirement with all of the facilities.

to request these data when the request is based solely upon the due consideration of the Defendants' request for fairness and accuracy, and our desire to find an objective method of monitoring this important issue in a manner consistent with the Stipulation. If the Defendants have an alternative method of providing data for assessment of the question of whether they have complied with their obligation to seek appointments for those Class Members requiring such with know release dates, we as always would be pleased to review them.

e. Pilot Project (¶¶34-35)

In our Second Quarterly Report, we required Defendants to continue to operate the Pilot Project without modifications. That is, we did not recommend that it be discontinued, as Defendants requested, citing low yield. We also did not recommend that efforts to determine release dates from attorneys be expanded to other jails, as it was not justifiable based on the results reported. We made several recommendations in that report, and since that time have repeatedly recommended that discharge planners involved in the pilot (and indeed all discharge planners) be provided with the technical supports needed to effectively do their jobs, including voice mail and e-mail.

DOHMH has repeatedly asserted that the results from this pilot are negligible, and that attempts to contact attorneys do not yield sufficiently useful information (qualitatively or quantitatively) to justify the expenditure of staff time and effort. Our response is simply that in the absence of voice-mail and/or e-mail capabilities for the staff, it is impossible to ascertain whether or not attorneys have attempted to reach discharge planners. DOHMH advised us last month that the discharge planners have voicemail - although our initial tests of this capability indicate that it is not fully implemented - and will soon have e-mail fully available, albeit in a central, rather than point-of-service, location. We expect that by the time of the next report we will have reasonably reliable information upon which to make a definitive determination regarding the need to continue this pilot project.

f. Monitors' Access to MIS

DOHMH informed us that they rejected a Web-based approach to maintaining the Management Information System ("MIS") database. As a result, they will not be able to

provide us with access to the MIS via the internet. We discussed with DOHMH alternative means of gaining this access, and they proposed that they make available to us a terminal upon demand at their offices located at 225 Broadway. They indicated that this terminal was not generally in use, and that as such we would have access upon short notice, and would not impede DOHMH business by using the terminal. While not as convenient as web-based access, this would appear to be an acceptable alternative.

On May 14, 2004, one of the Monitors went to the DOHMH offices at 225 Broadway. There, he was shown the terminal identified for the Monitors' use. Additionally, DOHMH provided a username and password. The Executive Director of DOHMH Division of Health Care Access and Improvement, Bureau of Correctional Health Services Administration, instructed the staff there that the Monitors were to have free, unimpeded access to review information on the MIS. While there, the Monitor logged on to the system, received instruction regarding its use and limitations, reviewed random entries, asked clarifying questions, and copied the available screens. On May 20, 2004, both Monitors went to 225 Broadway and reviewed the database. We continued to find our access to the terminal acceptable notwithstanding our concerns about the content and capabilities of the actual program. However, what we have not yet explored with Defendants is their ability to provide the statistical/data analysis expert(s) we are actively recruiting access to the raw data, to be used in our own analysis of that data.

g. Development of Performance Indicators

In our Third Quarterly Report, we outlined our thought processes regarding the development of performance indicators as required for the monitoring of this settlement. Briefly, we recognized the difficulties of operating a clinical and discharge planning

program within the confines of the correctional environment, especially one as chaotic as a large jail system. We outlined our approach, which included a division of tasks broadly into those already in place and operational and those that were not done or even contemplated prior to the instant litigation. Our thinking is to expect higher compliance, at an earlier date, for the former tasks as compared to the latter, as we expect a delayed "learning curve" on the part of Defendants for more fundamental changes. In formulating our approach we also employed a division along chronological lines. Under this construct, upstream issues (defined as tasks taking place earlier in the discharge planning process) appear more relevant early in our monitoring, while relative downstream issues (defined as tasks taking place later in the discharge planning process) are of lower priority until upstream issues are being performed at a high rate of compliance.

We wish to specifically address how we resolve an issue of contention between the related to the performance measures. The Plaintiffs asserted that we should have promulgated final performance measures at the six-month mark (December 6, 2003), and cite as authority ¶140 of the Stipulation. The Defendants, to summarize, proposed forcefully that we should not issue final measures in the absence of meaningful base-line data on actual performance. Defendants asserted they could provide us with such data at the end of this reporting quarter in time to be incorporated into this current report. (The data provided, as well as problems raised by the process of the provision of this data, is discussed in §IV of this report.) Further, Defendants asserted that such data should guide the way performance measures are set. For the reasons discussed below (see section IV.A.1.), we do not yet have from Defendants a full set of valid data, even from this

truncated cohort.[7] Additionally, we are not convinced that our ultimate expectations of compliance should be tied to the current state of affairs. We are, however, entirely of the belief that reasonable expectations for improvements in performance over time are fairly tied to actual performance. That is, the current level of compliance should not dictate the degree of compliance required to attain a finding of substantial compliance, but is the only logical starting-point for creation of a blueprint for how to get from the present level of compliance to substantial compliance.

For these reasons, we now set forth our first set of performance measures (see Appendix 3).[8] All measures will be examined and revaluated as provided for in ¶146, but we believe we cannot engender further delay in issuing our measures. Although we understand the Defendants' reluctance to accept this approach, we believe that having

[7] In meetings held with Defendants subsequent to the publication of our Third Quarterly Report, we were advised that Defendants would be able to provide us with complete data regarding discharge planning tasks for a cohort of Class Members released during the three month period between January 15 and April 15, 2004. Defendants instead provided us with data for inmates "identified by Mental Health between January 15 and April 15, 2004 for an M to be entered into DOC's IIS". As a result, many of the data contained in this report reflect what has or has not occurred for this limited group, not the entire Class during this period. (We accepted this data, as it was the only data provided; however, it should be clear that this is a very different group of inmates and makes it difficult for us to review all aspects of the discharge planning process, and in particular the "downstream" issues that do not occur until at or near the time of release.)

[8] Under separate cover, we are issuing two measures not appended to this report: (1) a draft of a performance measure concerning appropriate housing pursuant to 142 (m); and (2) a revised draft of a measure on engagement of the Class Members which we issue as necessary to effectuate the terms of the Agreement pursuant to ¶144. Defendants, in their written response to the draft of this report, object to the development of a process-oriented performance measure, stating: "It creates a new requirement for Defendants… which goes beyond the terms of the Stipulation, and [it] creates a performance measure based on the subjective assessments of the Monitors. Any process-oriented performance measures are highly objectionable as impeding on the discretion of the agency to draft and administer its own procedures. Results, not process, should be measured. Anything that concerns process should be viewed as a recommendation." We disagree. The measure does not include any measure of refusal; it is clear that Defendants cannot be held responsible for the *act* of any particular Class Member who refuses to accept their services. However, the measure does explore Defendants' actions in mitigating and in responding to Class Members who refuse discharge planning services and attempts to measure the degree to which the process does not unreasonably exclude Class Members from the rights and benefits of this Stipulation. In our view, such a measure explores actions of the Defendants which are legitimately within our purview as "necessary to effectuate the terms" of the Stipulation pursuant to ¶144.

These two measures are put forth in draft form to permit a ten (10)-day comment period by the Parties. We will, within ten (10) days of the end of this period, issue official versions of these measures.

more definitive goals and expectations will be useful to Defendants as they engage in strategic planning and mobilization of their staff to meet them. From both an organizational and monitoring perspective, the time has come to move beyond theoretical discussions about the quality and quantity of the measures, into monitoring and improvement of actual performance "on the ground."[9]

After our Second Quarterly Report, we circulated a document among the Parties detailing our thoughts about the performance measures. This document, which contained detailed draft indicators as well as a suggested monthly report to capture the data required to monitor them, stimulated much discussion, which was summarized in our Third Quarterly Report. After due consideration of the discussion, and after review of the data supplied by Defendants for this report, we have finalized the performance measures in the following way:

1. Paragraph 145 provides for a six-month period following the date we issue performance measures during which Plaintiffs are barred from seeking supplemental relief in the form of an Order from the Court compelling Defendants to meet a performance standard set in the indicators. Based upon our fact-finding to date and our knowledge of service delivery within correctional and other complex systems, we do not expect that Defendants will in fact, within this six-

[9] Although we believe that the process we followed in devising these indicators makes these matters clear, we wish to explicitly acknowledge and state: (a) The performance indicators we have issued pursuant to ¶142 contain several measures which involve an element of clinical judgment. (b) Therefore, in accordance with ¶143, we will assess compliance with the performance goals set pursuant to 142 (b), (c), (d), (i) and (m) in light of the accepted range of clinical standards, an approach acknowledged by the Parties in ¶143. (c) Our opinion is that the draft measure we circulated entitled Engaging Class Members in the Discharge Planning Process is necessary to effectuate the terms of this Stipulation, pursuant to ¶144. (d) Although we believe that the Engagement measure is more fairly put in terms of a "process" measure rather than a percentage of refusals, we revised our draft to express each element as a percentage of compliance with a particular element of the process to comport with the requirements of ¶141 that each goal shall be expressed in terms a percentage and to provide the Defendants with a discernable compliance goal.

month period, be able to attain across-the-board compliance with the *ultimate standards* we require for a finding of substantial compliance. We intend to monitor Defendants' compliance report-to-report in order to determine an appropriate rate of change on each measure over the course of each subsequent monitoring period. This process will rely heavily upon obtaining and analyzing what we expect to be increasingly accurate and complete monthly data from the Defendants.

2. The measures are greatly simplified from our initial draft. In these simplified measures, we provide only two numerical measures: (a) our expectations of Defendants over the next reporting period; i.e., what we at this time consider to be acceptable rates of compliance over the next reporting period (i.e. four months)[10] given the stage of development of Defendants' capacity to provide the requisite services and report their activities; and (b) our ultimate measure of substantial compliance ("substantial compliance measure").[11] Our indicators will not at this time detail interim steps to be achieved between our initial short-term goals and the substantial compliance measure, nor do they project a specific time course for changes in our expectations of Defendants' performance. Rather, new expectations will be set at the time of each subsequent report, following an

[10] Effective this report, we will be filing routine reports every four months (see ¶149). As there is no routine term used for a four month period (e.g. a "third" of a fiscal year), we will routinely use the term "reporting period" to denote the period between our reports and for which we will require data from Defendants.

[11] The Stipulation provides us with the requisite flexibility to revise, or issue performance indicators based upon review and experience, and we expressly state our intention to do so as the state of compliance as well as the reliability and validity of data-collections evolve over time.

analysis of Defendants' degree of progress in reaching the short-term goal in the preceding quarter.

3. By way of example, if Defendants currently comply with a given requirement 25% of the time, we might set a short-term goal of 50%, indicating a reasonable expectation of progress during the reporting period to come. If, following an analysis of the data for that quarter, we find that Defendants have achieved this goal, we might set a goal of 65% for the next reporting period; conversely, if Defendants achieve 40% we might maintain 50% as the next short-term goal. We will conduct this analysis irrespective of the degree of compliance which we require for an ultimate finding of substantial compliance.
4. The measures in Appendix 3 focus on basic aspects of the Stipulation, with special, but not exclusive attention to what we consider key initial aspects of compliance, as described above and in our Third Report. If Defendants are consistently out of compliance with a given measure, we plan to break the measure down into component measures to drill down and attempt to determine where in the process the breakdowns are occurring.
5. In order for us to monitor Defendants' performance, we request that Defendants provide the data elements contained in the attached worksheets (Appendix 4), on a routine basis each month. We will hone our requests based on our analysis of the data provided, and as we modify and expand the measures as discussed above. Additionally, we may, from time-to-time make special requests of the Defendants for data or narrative responses to questions regarding compliance-related issues. The format of these worksheets makes clear that some data on these elements of

performance will come from data generated by Defendants, some data will come from our chart reviews, and some may be available from both sources. In addition to figures which address specific data-points found in the performance measures, these worksheets now builds into it our standing data request of Defendants (which was originally submitted to them for our Third Report and which we kept identical for this report for simplicity and clarity). Some of the data we request are not the performance measures themselves but are parts of denominators or otherwise inform our analysis of the data provided. These worksheets in their entirety make up our current routine monthly data request; for each report we may make supplemental or special requests in addition to these worksheets.

6. Pursuant to ¶140, we will account for the limitations imposed by the jail environment with the following provisos:
   a. Data regarding the incidence and prevalence of these limitations must be provided by Defendants[12], or

[12] We note that Department of Corrections Operations Order 03/03 provides in Section III B (Escort and Tracking) *inter alia* that mental health and discharge planning staff will provide DOC clinic staff with written call-down sheets to produce inmates (form #968R); that an inmate's appearance at the discharge planner's office will be recorded in the Automated Clinic Tracking Program; that inmates are not permitted to refuse a mental health discharge planning appointment in the housing unit; that "The office assigned to the clinic/discharge planning post will be responsible for investigating the reason(s) for any non-appearance of an inmate on the mental health discharge planning call-up list by utilizing the Mental Health Daily Encounter Form/Call down sheet. This information will be provided to the mental health discharge planner daily, and will be maintained in the Deputy Warder of Programs office." (¶III 5). Thus, it appears to us that that statistical data regarding the reason that a class was not "produced" by DOC for requested appointments should be fairly accessible. Provision of these data and subsequent analysis would allow us to engage in a substantive discussion with the Parties as to what reasons might be consider acceptable in this regard. Such a process of data collection and analysis would also, in our view, stimulate meaningful discussions as to how best to mitigate such factors and would also increase accountability—all desirable results in addition to allowing us to fairly account for unavoidable obstacles.

b. We will make reasonable but conservative estimates based on our experience in correctional settings.

7. We will take margin of error in the data reporting and analysis process into account after consulting qualified experts in the field of statistics.
8. To summarize the approach we will take:
    a. We are now issuing short-term goals for performance from one report to the next.
    b. We will titrate short-term goals based upon our findings in each report, both substantively and in terms of data collection improvements. These goals will be irrespective of the thresholds we set to measure substantial compliance.
    c. We are now issuing untimed measures of ultimate substantial compliance; i.e., the mark Defendants must obtain over the course of time for us to issue a finding of substantial compliance with the Stipulation.
    d. We will adjust, add to, subtract from, or otherwise amend our measures in accordance with Section IV.D as required. These modifications, additions and subtractions will take at times both substantive forms as well as statistical adjustments required to increase the validity of our findings from a technical viewpoint.
    e. We will initially emphasize upstream issues, but continue to investigate key downstream issues.
    f. As upstream issues are addressed and as data collection improves, we will increase the intensity of monitoring of contingent downstream issues.

g. If compliance figures reasonably match our expectations of short-term compliance goals, we will maintain the approach taken by our substantially simplified measures; however, to the extent that report-to-report analysis indicates significant deviation from these goals, we will introduce the more step-by-step approach delineated in our draft indicators so that the point or points of breakdown are isolated.

h. Reorganization within DOHMH

1. Structural changes

DOHMH is moving ahead in a serious manner to realize the long-awaited and necessary goal of restructuring the mental health discharge planning service delivery model and skill mix. Although the efforts appear to us to be authentic, the results are yet to be fully realized. Further, while we understand DOHMH's rationale for wishing to link the schedule for implementation of this plan to the results of their recruitment efforts, the timeline for fully realizing this plan remains unacceptably vague. Defendants' plan anticipates what we expect will be beneficial revisions on a variety of different levels of organization: (1) skill mix of discharge planning staff (training level, language abilities); (2) location and allocation of staff (jail-based; shifts); (3) functioning and responsibilities of staff within discharge-planning; (4) co-ordination of staff with jail-based mental health services (case conferences); and, (5) enhancement of appropriate communication capabilities (voice-mail; e-mail).

Our overall reaction to and assessment of this plan vis-à-vis the current state of affairs is not unlike our assessment of global progress. On one hand, the plan is sound and significant breakthroughs occurred during this quarter; on the other, as

assessed from the perspective of progress at the one-year point of this monitoring period, overall progress has been unacceptably faltering. Having said that, we do see very encouraging signs of sustained efforts at making meaningful progress, and an attitude which does not accept at face-value the refrain commonly encountered in correctional settings across the country that certain gains cannot be realized simply because of the jail environment or because nobody has done so in the past.

2. Details of Plan

As described to us by DOHMH, the restructuring plan when realized calls for a total of twenty-four (24) Masters-level discharge planners ("Discharge Planners"), twenty-five ("25") Bachelors-level Caseworkers/Entitlement Specialists ("Caseworkers"), nine (9) Supervisors, one (1) Directors, and one (1) Deputy Director, with support staff. The plan is to have bilingual staff, with initial emphasis on Spanish and French, and with follow-up efforts to obtain Russian and Chinese language capabilities.

With the exception of the DOHMH Assistant Commissioner who oversees discharge planning activities, all of these staff, including the DOHMH Director of Discharge Planning will be situated within a City jail. Staff will no longer be responsible for discrete tasks such as "document control" or "client contact", an arrangement of which we have been critical. Rather, the Caseworkers will be responsible for all functions related to securing benefits for the Class Member upon release such as Medicaid and Public Assistance. The exception to this will be the

completion of the HRA 2000 application and attendant issues.[13] The Discharge Planners will perform other discharge planning functions such as attending treatment team meetings, securing mental health follow-up appointments and referrals and other placements, the HRA 2000 application, regular follow-up with Class Members when appropriate, and other related tasks. The Discharge Planners will have specific caseloads, with the current thinking being that they will take responsibility for duties based upon housing area.[14]

Discharge planning, caseworker staff will be assigned to cover all Rikers Island jails seven (7) days a week on two shifts, 8:00am-4:00pm and 4:00pm-12:00am. A pilot project will assign one discharge planning staff member to cover the 12:00am-8:00am shift on Rikers Island.[15]

When fully implemented, staff will have access to e-mails via direct lines at each facility, and the MIS system will be available on Rikers Island.

3. Current State of Implementation of Plan

The ultimate plan described in the section above is in varying stages of implementation. The most recent information provided to us by DOHMH is as follows.

[13] This exception is to us logical as this procedure requires the assembly—in both the conceptual and concrete meanings of the word—of complex clinical assessments and information.

[14] We understand the functional difficulties of having a staff person follow a particular client throughout the incarceration and possible changes among housing areas, institutions, and levels of care. We note clearly and from the outset, however, that division by housing area will make staff communication—via the chart, via telephone calls, via e-mail, as well as consistent and regular chart review upon transfer--- essential to continuity of care. This is so both as a tracking matter (i.e., not losing the person to follow-up upon transfer), and as a quality of care concern.

[15] Covering this "midnight" shift may prove crucial in allowing for contact for those Class Members who are unavailable during the earlier shift because of regular court appearances.

Three additional supervisors commenced duties on March 8, 2004, so that there are now a total of nine (9) supervisors. Of these, five (5) have Masters Degrees. Of the remaining four (4), three (3) are in MSW programs.

Four new Masters-level Discharge Planners began employment on March 29, 2004, with one resigning shortly thereafter, for a net gain of three.

Four additional Masters-level Discharge Planners have completed the employment process and are scheduling to report to duty on May 24, 2004.

DOHMH identified eleven (11) more Masters-level Discharge Planners, and they are currently under-going the employment process.

Currently, there are six (6) open positions for Masters-level Planners. Of those open positions, three (3) were interviewed and identified as candidates. There are currently three (3) open caseworker positions as a result of resignations.

Plan for the Recruitment and Hire of Masters-level (MSW) Discharge Planners (Direct Service Staff)

Started 3/29/04 and currently employed	Processed, will commence 5/24/04	Identified, in processing phase	Interviewed, identified	Open positions without any candidate identified for employment
3	4	11	3	3

Currently, of the Discharge Planning staff, three (3) speak Spanish, two (2) French (Haitian Creole), and one (1) Russian. Of the present Caseworker staff, three (3) speak Spanish and one an unidentified African language. DOHMH informs us that they have a "language bank" available as well whereby the can call and within minutes obtain telephone interpreter services in a wide range of languages; however, as of this date, DOHMH reported to us, this service was used on only one occasion: to

secure means of communication with a deaf Class Member. Generally, they report that they attempt to utilize the interpreter services of bi-lingual staff. We have requested more detailed information as to the frequency and utility of this method.

Current Language Capability of Discharge Planning Staff

	Discharge Planners	Caseworkers	Total
Spanish	3	3	6
French/Creole	2	0	2
Russian	1	0	1
African Language	0	1	0
Chinese	0	0	0

According to DOHMH, the CRU/benefits Units, located at 346 Broadway in Manhattan accounted for seven (7) staff members, six (6) clerical personnel including "temp" workers, and two (2) supervisors. As of the writing of this report, DOHMH reported that of these, two (2) caseworkers were redeployed to Rikers Island, and one to the "BBKC" facility in Manhattan. Defendants state that they are working "aggressively" to have data-base (MIS) capability on Rikers Island, and that the entire CRU/Benefits Units will be moved to Rikers Island once this is accomplished.

As regards the general restructuring of discharge planning services and allocation of responsibility, DOHMH plans upon introducing the new service delivery model on a building-by-building basis in the larger facilities such as AMKC, GMDC, EMTC, OBCC, ARDC and RMSC so that it can be adequately monitored and adjusted. The agency anticipates that they will be able to group the change-over among the smaller facilities such as VCBC, NIC and West Facility. Defendants inform us that this

model is currently in effect at Bernard B. Kerik Center ("BBKC") in Manhattan.[16] The next scheduled building for this change is scheduled to be AMKC/C-71. The precise time-line for implementation is contingent upon recruitment efforts which were not originally as smooth as had been hoped, but now appear to be yielding demonstrable results.[17] We plan upon monitoring progress of this important, fundamental alteration, and urge a set and expedited timetable for full implementation.

4. Communications Capability/Technological Issues

[16] The Monitors conducted a site visit to BBKC on May 24, 2004 and one of the Monitors returned to that facility on May 25 with the social worker. We found the new model and the desired changes to be only partially implemented. Commendably, the site now has a bi-lingual (English/Spanish) MSW discharge-planner with relevant experience, as well as a bachelors-level caseworker. Between the two staff members, discharge planning is present in the facility between 8:00am and 8:00pm, Monday through Friday. Discharge planning and mental health staff reported that joint case conferences are being held on a daily basis, including once a week on the evening shift. Discharge planning staff see inmates as soon as possible after they are assessed by mental health as requiring follow up, and at times staff reported that the first discharge planning contact occurs during the same clinic visit. During this initial visit, inmates are given the required brochures, are introduced to discharge planning services, and the pre-screening is conducted. Notably, mental health and discharge planning staff report an almost negligible incidence of refusals of discharge-planning services despite the recency of incarceration and all its attendant stressors. If the person is not discharged or transferred, he is seen again following the CDTP assuming that services are required.. The plan - of which our initial chart reviews did not uncover evidence at present - would be for discharge-planning to then see the Class Member on an on-going basis.

On the balance, these are very positive developments. However, the new model, with its division of labor, has not been established at BBKC; the explanation given by staff is that they work collaboratively and interchange roles well, and that this is more efficient. Also, there is no computer access aside from the IIS, no e-mail, and no voice-mail available to the discharge planners. Further, while we are very supportive of the changes made and the positive attitude of the staff at the facility, our chart review over one day did not find evidence of many of the actual improvements we would hope to see grow out of the structural changes. For example, our one-day chart review did not find evidence that the SPMI assessment or form is being completed at this facility. Additionally, staff were unaware of any provisions to provide transportation for any eligible Class Member released from this facility. Staff continue to operate under the misconception that §IV.C.5. (Housing) is applicable only to SPMI Class Members, in our view a misreading of the Stipulation. Further, a request of the Deputy Warden for programs concerning adherence to DOC Operations Order 03/03, §III.B.5 indicated that the Deputy Warden was unaware of the requirements of this DOC Operations Order and was unable to provide us with the relevant information, which is to be maintained in his office.

[17] We request from Defendants the delineation of more precise schedule and accelerated timeline for completion of this fundamental and important task. Again, while we understand Defendants' concerns, time is truly of the essence as sustained, systemwide improvements in actual performance are less likely to occur until this over-due reorganization is fully implemented.

All Discharge Planning and Caseworker staff now have electronic mail accounts which DOHMH instructs them to access periodically. However, currently in order to access e-mail Discharge Planners must go to the West Facility trailer, where DOHMH reports five (5) terminals are available for their use. DOHMH informs us that the requisite hardware and wiring is being installed to allow each staff-member e-mail access in their respective facilities: computers are on order and Defendants are in the process of securing lines to connect them to e-mail accounts. Staff now have shared voice-mail available in most facilities, according to Defendants. Site visits to BBKC indicated that staff does not have voice-mail at this facility, and we are told that voice-mail is unavailable at VCBC;[18] additionally, DOHMH informed us that they are experiencing technical difficulties in setting up the voice-mail system in one facility, ARDC. Thus, once the technical issues are resolved at ARDC, all Rikers Island facilities should have some voice-mail capacity for discharge planning staff, an important accomplishment. An analysis of a listing of all discharge planners and their telephone numbers revealed a mixture of shared and separate voicemail accounts. For example, for AMKC six (6) discharge planners are noted, all with the same number and presumably the same voice-mail box, while at OBCC three distinct numbers are noted. Overall, the preponderance of facilities appear to utilize shared lines. This is not inappropriate *per se*, but could be problematic if there are other numbers

[18] During a recent site visit by one of the monitors and staff to BBKC, the discharge planner vacated her office to allow permit them to perform Class Member interviews during her lunch hour and beyond. During approximately one and one half hours, the telephone rang numerous times. The monitor answered the telephone on three of those occasions to take messages for the discharge planner. One of those calls was from a discharge planner-colleague and another was from Manhattan LINK about a client. Presumably, the discharge planner would not have received some percentage of those messages in the absence of voice-mail had the monitor not been there to receive them.

associated with discharge-planning in a particular building which are not connected to the voice-mail system.

On May 31, 2004, a legal holiday, one of the Monitors made test calls to all of the discharge planners' numbers which were represented as having voice-mail rollover. No calls were made to BBKC or to VCBC at that time. A total of 16 calls were made to 12 unique phone numbers. At five of the numbers, the phone was allowed to ring for a full minute and there was no voice-mail rollover. At a sixth number, four attempts were made: two attempts resulted in a busy signal, and the other two attempts resulted in no connection. At four numbers, the first call resulted in a voice-mail rollover.[19] At the last two numbers, a discharge planner answered the first phone call. Each time, this individual was asked to let the phone ring so that I could test the voice-mail rollover. At each site, the first attempt at such a call resulted in no voice-mail rollover after a full minute. At one of the sites, a later call was answered by the discharge planner who offered to check the voice-mail system; a call about 10 minutes later was picked up by voice mail. At the other site, the discharge planner informed me that she did not believe the voice-mail system was working as she "never gets any messages". It appears that Defendants still have not reliably provided their staff with this key tool in the provision of discharge planning services (including, but of course not limited to, the pilot project of ¶¶34-35).

The current state of affairs does not yet fully achieve the aims we originally conceived in recommending access to e-mail – ease and speed in communicating and

[19] Messages were left at these numbers; two calls were returned on 6/1/04, and the other messages were not returned.

accessing Class Member information, improved communication among staff, and increased accountability. Nonetheless, the provision of email accounts to discharge planners represents an important step forward. The need for improvement in these areas relates as well to our observations made below regarding the need for reliable and consistent access to the MIS system for all relevant parties. Like the current DOHMH leadership, we do not accept the myth that the correctional environment by its nature renders undoable such needed improvements. While the obstacles as we have consistently noted are real, it is precisely the challenges presented by the jail environment and the complexity of the multi-agency tasks required by this discharge-planning endeavor which make such reliable access to information and communications essential to success.

5. Case Conferences/Team Meetings

DOHMH reports, and our observations confirm, that team meetings are occurring between discharge planners and mental health staff on both a regularly scheduled and as needed basis. Our understanding is that cases are discussed and that the physical transfer of the CTDP and DSN between the services occurs at this time. This reduces unnecessary lag time as well as the likelihood of paperwork getting misplaced. DOHMH informs us that the focus groups they conducted about this process suggest "very positive" feedback from staff. This, too, is a beneficial development, as staff "buy-in" improves the likelihood of success.

6. Related Observations

Connected with this notion of training and skill mix discussed above is the issue of obtaining an appropriate level of aftercare mental health services. In many

instances, arranging for access to appropriate mental health aftercare in the community, either via referrals or appointments as the case may be, is central to successful discharge planning efforts. Discharge planning staff who do not fully understand diagnosis and clinical terminology are considerably less likely to be able to discuss the case with a community provider, or (and this is a component of any good discharge planning service) to appropriately advocate for their clients when they are improperly rejected from needed mental health services. This relates to one of our overall observations that in many cases discharge planners make early contact with a Class Member, and then only return to engagement with the Class Member when release appears imminent. While the bookends (beginning and end) of this contact timeline would be appropriate in many cases, what is not uncommonly missing is the interim contact which sound discharge planning generally entails. Both the client and the receiving agency (in the case of community-based mental health care) must be educated about one another for the process to succeed. This requires a longitudinal understanding of the client on the part of the discharge planning staff. In other words, a one-time discharge planning assessment and referral is insufficient for many Class Members who remain incarcerated for a substantial period of time.

i. State of Data Reporting

For this stage of the monitoring process, we greatly simplified and reduced the regular data request we make of Defendants. Additionally, in order to attempt to secure a set of data which would be reliable and valid for this reporting period, we agreed to limit our request of DOHMH related to this report to Class Members who received an "M" designation between January 15, 2004 and April 15, 2004 (though our initial request was

for data on all Class Members who were ***released*** during that same date period). We did so based upon Defendants' representations that this limitation would allow them to provide figures they could report with confidence. This approach yielded only partially satisfactory results. Defendants now inform us that these data are only fully reliable and valid as they relate to aspects of the Stipulation connected to Mental Health staff functions as opposed to the activities of the discharge planners. DOHMH appears to be attempting to improve this situation both in the long-term through the contract with "DOITT" we referenced in our Third Quarterly Report, and in the short-term through intensive supervision and discussion with the staff in the jail facilities responsible for collecting and inputting data. Nonetheless, of a piece with so many of our observations related to a number of critical areas of compliance, these obviously intensified efforts at achieving compliance have yet to produce acceptable, demonstrable results.

Having spent an initial and follow-up session reviewing the MIS, we have similar observations. While appearing to contain most or all of the screens required by Exhibit A of the Stipulation, an initial, random search of entries in the system, seemed to reveal a significant number of missing entries.[20] Our impression was that the incidence of blank fields and data-points lessened when a cohort of more recent (but not new) admissions was reviewed. Nonetheless, now based upon two sessions of review, some important data-points are consistently missing on the more recently entered cases. Examples of commonly or universally missing data elements included the psychiatric diagnosis, the Global Assessment of Functioning (GAF), and any psychiatric medications prescribed for

[20] This observation is consistent with the reports of SPAN staff and our reviews of the MIS data-base when we have conducted site visits to the SPAN offices.

that Class Member.[21]. What is indisputable, though, is that the MIS is not currently capable of producing the reports referenced in ¶124 of the Stipulation. While it is true that the MIS appears to have most or all of the fields referenced in Exhibit A to the Stipulation, many of these fields are not populated or completed and therefore are not useful in generating reports necessary for monitoring of Defendants' performance. As such, it does not comply with the requirements set-forth therein. The current state of the MIS deprives Defendants' leadership of what should be a very powerful management tool. DOHMH is aware of these deficiencies and has remedial action planned.

III. Content

A. Monitoring of Jail-based services

1. Data from Defendants

Defendants responded to a number of requests we made regarding the provision of mental health and discharge planning services pursuant to the Stipulation. As discussed in our Third Report, Defendants indicated that they would be able to provide us with data they believed would be reliable in time for this report. To maximize their chances of being able to meet this obligation, we elected to keep our request identical to the request we made for the Third Report, with some minor refinements made following discussion with Defendants. In this section, we will review data relevant to the jail-based services; other data will be discussed elsewhere in this report.

[21] These are key fields for downstream use: if, for example, a Class Member is transferred among jails, and the chart lags behind, a discharge planner could begin working with that Class Member if s/he was aware of the diagnosis and current treatment. Similarly, if a Class Member is released and goes to SPAN, the SPAN worker would be better equipped to seek appropriate aftercare given that information.

Defendants selected a cohort of Class Members who were incarcerated and given an M label between January 15 and April 15, 2004 for a total N of 3470.[22] Again, we note that our request was specifically for Class Members ***released*** between those dates, so the data provided was not precisely what we had requested. Nonetheless, we are able to use the data for some meaningful evaluations of Defendants' compliance.

a. LSPMI determinations: Defendants reported that 2268 of 3470 (65%) Class Members were rated as LSPMI. This indicates a very wide sweep by mental health providers at the time of the initial assessment. In discussion with Defendants, we were advised that they also noted this high rate of LSPMI finding and were working with mental health staff to balance the desire for a low rate of false negatives with a need to not be overly obligated to provide services where they are not needed. DOHMH and Prison Health Services (PHS) are working to ensure that staff members performing this task are adequately educated regarding this balance.

   We strongly suggest that the supervision and training of staff necessary to achieve this balance take place in the context of the fundamental mission changes which assessment of clinically appropriate discharge planning requires. In part, this includes incorporating the

[22] We support DOHMH's plan to secure computers and access to databases for the mental health staff and discharge planners in the facilities and to have the clinicians enter the "M" directly into the IIS. Again, however, we are aware of no specific timeline for implementation of this excellent idea. "Point of service" data entry will be in our view the most reliable and efficient way of obtaining valid and reliable data required for our monitoring as well as for the Defendants' own management needs.

LSPMI, SPMI, and HRA 2000 assessments (and also assessments for SSI and other benefits as discussed above) and integrating them with assessment of current functioning. Mental Health staff in the jails, by virtue of the mandates of the Stipulation which require in many instances the completion of a SPMI assessment, an HRA 2000, and the assessment of post-release needs via the CDTP and DSN, already perform these assessments. In other words, we suggest that Defendants will be better able to comply with all of these aspects of the Stipulation if they broaden the emphasis to include the collection of information regarding and assessment of both actual community-based functioning prior to incarceration, and anticipated post-discharge functioning. Addressing this issue would involve training and supervision as well as consideration of revising the assessment tools relied upon in making LSPMI and SPMI ratings and applications for relevant benefits.

We note that the current assessment forms, while comprehensive and lengthy, place meager emphasis upon the collection and documentation of the community-based functional level which is central to the SPMI, HRA 2000, and post-release needs inquiries. For example, in order to complete the SPMI assessment properly, the clinician must explore and assess community functioning on a variety of levels. By way of further example, in completing the DSN, mental health staff must synthesize information concerning previous functioning, current mental status and diagnosis to develop a suitable assessment of post-discharge need. It is precisely our

comprehension of this need to rethink the nature of assessment in order to appropriately accomplish these tasks which leads us to expect an initial lower level of compliance in for example the SPMI area than in the area of timely completion of mental health assessment-- a task which has long been a function of mental health staff within the New York City correctional system.

To the extent that staff is guided in their clinical interview questioning by the structure and emphasis of the forms they must complete, they may not fully gather the data nor conduct the analyses required in these areas as long as the assessment tools remain in their current configurations. We continue to support the previously-noted idea of revising these assessment forms so that they guide mental health staff in conducting these tasks. We foresee a time when mental health staff, in completing the initial assessment(s) and CTDPs, will routinely include all or most of the information needed by a discharge planner in applying for needed benefits and services on behalf of a Class Member. This of course is not a substitute for adequate supervision and training, but would be a useful part of the process of what we have previously described as a fundamental mission-shift for the jail-based mental health staff: moving beyond their mission as previously conceptualized to an inclusion of an assessment of pre and post incarceration functioning in the community and the services required to maximize that functioning. While this is being completed, we

support the erring on the side of over-inclusiveness, which can and should be corrected for during subsequent assessments.

b. Attrition: A total of 1532 Class Members in the cohort (44%) also were released during this time period. Of these, 526 (34%) were listed as having a "known release date". Upon discussion with Defendants, it is apparent that there are at least three groups of "known release date" Class Members:

    i. Those with a release date that is truly known and recorded in the IIS at some time period prior to the actual release date

    ii. Those with a release date that becomes known at court when the Class Member is sentenced to "time served"

    iii. Those for whom information regarding the release date becomes known to mental health or discharge planning who enter it into the MIS data-base but for whom this information will not appear in the IIS.

    At this time, Defendants are unable to sort out the first two groups, a relevant issue given the requirement for Class Members with known release dates to be given mental health appointments rather than referrals.

    A total of 29 Class Members (0.8% of the cohort) with an M designation were released from jail prior to even having an initial mental health assessment. A further 1135 (33%) were released at some point between the mental health assessment and the CTDP. This is slightly higher than our finding in our Second Quarterly Report that about 27% of

Class Members are released on or before day 19 of their incarceration. Two explanations likely make up this difference:

i. some Class Members are not referred to mental health immediately, but rather some days after incarceration

ii. some Class Members are released who should have had a CTDP but did not (see data on CTDPs below)

We repeat our conclusion from the Second Report that, given that slightly more than 1% of inmates with an "M" designation[23] are released per day, great attention must be paid to meeting the deadlines for these critical upstream tasks.

c. CTDP completions and SPMI determinations: Defendants reported that of the 3470 Class Members in the cohort, a total of 1555 remained incarcerated a sufficient period time to have had a CTDP. Please note that some of the Class Members who did not have a CTDP done were released in the interim (including a percentage of the 1532 discussed in the above section). Another group was admitted too close to the endpoint of the data reporting period (April 15). As such, their CTDP's were not yet due. Finally, some simply did not have the CTDPs done, despite having reached or past the due-date for completion.

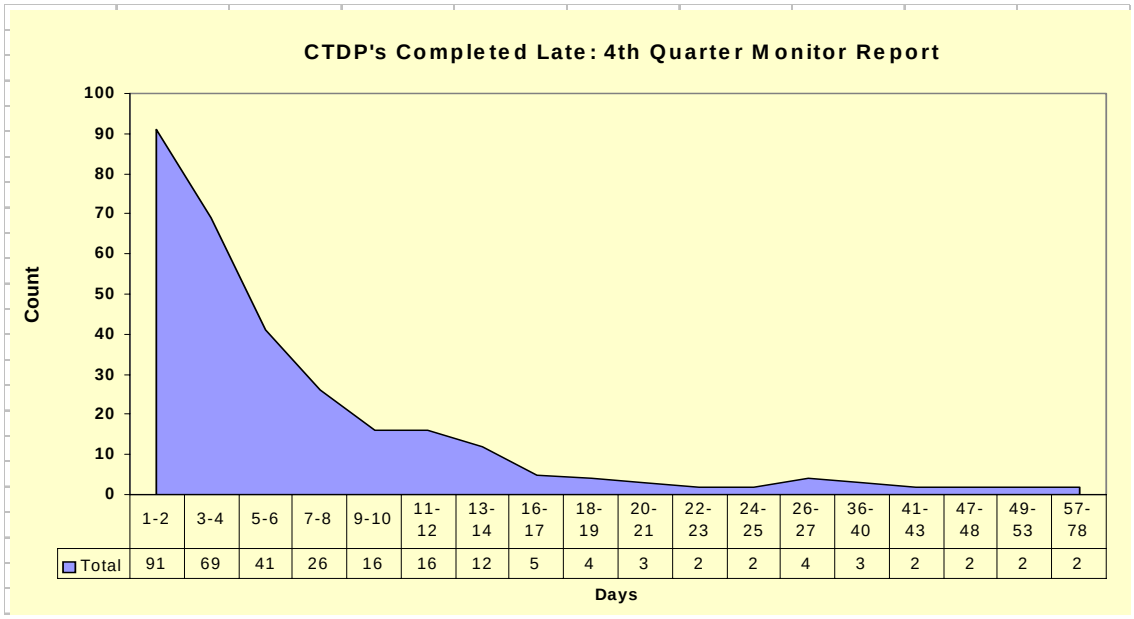
A total of 2002 Class Members should have had the CTDPs done during this reporting period. 1251 (62%) had them done by the due date,

[23] Note: in our Second Report, we reported that 1% of **Class Members** were released per day; here we correct this to reflect that these are individuals with an "M" designation, not all of whom are or will become Class Members.

and an additional 304 (15%) had them done after the due date. Defendants provided the following data regarding late CTDP's:

CTDP Days Late	#	% of late CTDPs
1-2	91	30%
3-4	69	23%
5-6	41	13%
7-8	26	9%
9-10	16	5%
11-12	16	5%
13-14	12	4%
16-17	5	2%
18-19	4	1%
20-21	3	1%
22-23	2	<1%
24-25	2	<1%
26-27	4	1%
36-40	3	1%
41-43	2	<1%
47-48	2	<1%
49-53	2	<1%
57-78	2	<1%
Date Error	2	<1%
Total	304	

Defendants were able to provide this same data in graphic format:



It is notable that of the CTDPs completed after the due date, two thirds (2/3) were completed less than a week after the due date.

As noted above, of the 2002 Class Members whose CTDPs came due during the reporting period, 1555 received this service in either a timely or untimely manner.[24] Again, of the 1555 who did receive a CTDP, 1251 (62%) were timely, and 304 (15%) were late. Two hundred and one, (or 66%) of the late occurrences completed less one week after the due date. This leaves 447 (22%) of eligible Class Members for whom mental health staff never completed a CTDP. Taken together, this signifies that 1899 (95%) of this entire cohort can be accounted for as:

(a) receiving a timely CTDP

(b) receiving a late CTDP within 1 week, indicating a formal lack of compliance but a pragmatic finding that the case was followed closely. These cases warrant interventions such as

- increased clerical and technological support (to provide reminders of upcoming due dates)
- increased numbers of mental health staff (to ensure adequate staff time for this important task)
- a study of reasons for the lateness in the group whose CTDPs were less than one week late

(c) never receiving a CDTP. It appears that these cases fell outside of Defendants' customary tracking mechanisms. Without knowing,

[24] While still unacceptably low, this is an increase of 12% in the completion rate (not timely compliance rate) from the last data-set we received. Do not know if this represents an actual improvement in performance, improved data collection in this area, or some combination of the two.

we suggest that likely categories for situations where this would occur would be Class Members transferred among numerous jails facilities; those cycling among General Population, Mental Observation and/or the Hospital Prison Wards; and those in other, specialized housing. It may also be the case that a particular facility or facilities can be identified which account for a disproportional percentage of the point of drop-off. It would also be instructive to study whether the failure to complete a CTDP is related to a loss to mental health and/or medical follow-up overall, or if this deficiency represents a discrete breakdown in the system for tracking and completing CTDP's.

We strongly recommend-- and we believe that Defendants agree and are beginning to take action in this direction-- that DOHMH institute careful and systematic study of the underlying causes of the failure to provide CTDPs for this unacceptably high number of Class Members. In keeping with our emphasis on "upstream issues" we, also, intend to focus monitoring resources and efforts in this area, which we suspect may be phenomenon discrete from those CTDPs which are completed, but completed late.

Defendants further reported that 250 CTDPs were past due on Class Members still incarcerated at the end of the reporting period, and that 195 CTDPs on Class Members who were subsequently released were past due. This latter group raises substantial concern, because these Class Members

were released without even the beginnings of a discharge planning process – a process to which they are entitled *per se* as members of the class.

Of the 1555 Class Members who had a CTDP, 475 (31%) were found to be SPMI.

d. Refusals of discharge planning: Of the 1555 Class Members for whom a CTDP was completed, 374 (24%) refused all discharge planning services. Other Class Members selectively refused some and accepted other services, and these refusals changed periodically (i.e. a Class Member might refuse one or more service at one point and then accept it later, or vice versa). This reflects a reduction as compared to our previous reporting that about one third of Class Members refused all discharge planning services and indicates improved engagement on the part of jail-based mental health and discharge planning staff.[25] Selective refusals (which may overlap with each other) were as follows:

The number who refused pre-screening	382
The number who refused community services	9
The number who refused a Medicaid application	381
The number who refused an MGP card	380
The number who refused supportive housing	352
The number who refused public assistance	28

e. Provision of mental health appointments and referrals to Class Members:

[25] As discussed in our Third Report, DOHMH did secure training for the discharge planners on engaging challenging clients. While we cannot draw a connection between this training and the reduction in refusal rate, neither can we rule it out. We do not have a bright-line number of where the refusal rate should ultimately fall, we certainly support any efforts to increase the number Class Members accepting services, and will, as we note above, monitor the process (as opposed to any given rate) of engagement and refusal.

i. Defendants reported that of 119 Class Members eligible for appointments (those who are in need of continued mental health care on release, who have a known release date, and who do not refuse this service), 17 (14%) were provided with such appointments. This finding concerns us because both the numerator and denominator seem very low. We believe that this denominator, at a minimum, based on the numbers provided, should be 526 (those released with known release dates) minus 374 (global refusers) minus 9 (refusers of community services) = 143.[26] Further we have great concern about the very low compliance rate (17/143 = 12%) on this key element of discharge planning and community transitioning for individuals with mental illness.[27]

ii. Defendants reported that 49 (24%) of 205 Class Members not eligible for appointments had referrals made to community mental health programs prior to release. These are Class Members who were released without a known/projected release date. We have similar concerns regarding this denominator: 1006 Class Members were

[26] Defendants, in their written response, object to our estimation of this denominator as some Class Members with a "known release date" are actually "time served" (i.e. the release date was only known at the time of release, and not before). Again, we would request that Defendants determine a way to separate out "time served" from those with a prospectively known release date. Even using the Defendants' denominator, however, Defendants are clearly non-compliant with this requirement of the Stipulation.

[27] In discussions with Defendants about this issue they raised the issue that community providers are unwilling or unable to give appointments for Class Members whose projected release date is too far in the future—more than a month or in some cases weeks. We do not find this to be an acceptable reason for this failure as the appropriate timeframe for referral would by necessity arrive at some point during the Class Members' incarceration. We suggest that Defendants work to ensure that as these Class Members get closer to their release date, discharge planners remain in contact with these Class Members in order to arrange for these appointments. We believe that as the restructuring of discharge planning services is implemented as planned, this will occur and encourage Defendants to proceed as quickly as possible.

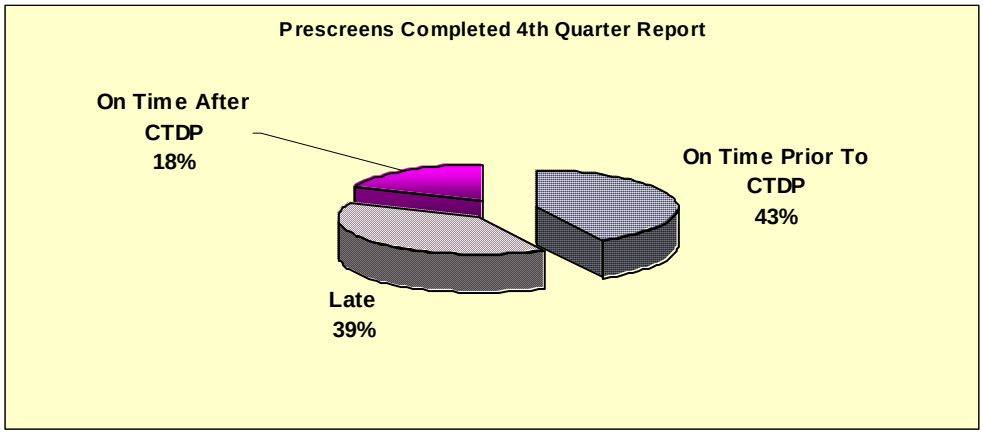
released without a known release date during this reporting period. Conservatively, this denominator should be 1006-374-9 = 623. Using this denominator, the compliance rate for referrals is 49/623 = 8%.

iii. Defendants report a very low rate of attempting follow up calls regarding the appointments and referrals they do make for Class Members who are SPMI. Thus, for the 17 Class Members who had appointments, 8 (47%) were SPMI. No follow up calls were made or attempted for these 8 Class Members. Similarly, of the 49 Class Members who were given referrals for aftercare, 18 (37%) were SPMI. Follow up calls were attempted for only 1 (6%) of this group. This attempt was unsuccessful. These follow up calls are in theory very simple – all that is required is a call to the clinic/program to which the Class Member was referred (¶49). If the Class Member is reported by that program to have failed to keep the appointment or follow through on the referral, attempts are subsequently be made to reach the Class Member to arrange for another appointment. However our reading of the data provided is that even the first, simple step, is not being done at this time.[28]

[28] One reason for confusion at this step could be that the responsibility for these follow up calls falls to two separate parties – "Defendants" and LINK (see ¶49). We have been given various pieces of information, often conflicting, regarding the interaction of LINK with discharge planners and with Class Members. We recommend that Defendants create a clearer operational procedure regarding these follow up calls and more generally that Defendants ensure that discharge planners have accurate information regarding the role of LINK. Additionally, we will incorporate a more detailed understanding of the functioning of the LINK programs into our monitoring operations at a future point in time.

f. Medicaid Prescreening: DOHMH reported that 304 prescreenings were completed within the 3 day timeline required, out of a total of 1108 eligible for this service (27%). Excluded from this denominator are Class Members who refused to have the prescreening done and a small number who were released between the date of the CTDP and the deadline for the prescreening. Regarding this last exclusion, we have no data at this time but will require it in the future.

A separate data set from DOHMH, regarding all prescreenings done during the reporting period, indicates that a total of 1112 prescreenings were done during the period. This data set includes findings on timeliness: 61% of these were done timely (43% reportedly were done **prior to the CTDP**), and 39% were done late (see the chart below provided by DOHMH). However, no data was provided regarding the denominator, so we are unable to determine an overall compliance rate.



This report from Defendants warrants comment. We certainly applaud any effort on Defendants' part to accelerate engagement with Class

Members, whether required by the Stipulation, or in this case even when it is not so required. Given our findings regarding the rate of attrition, we would be hard-pressed to find fault with the intent behind such an approach.[29]

Notwithstanding this laudable effort at early intervention, the overall compliance rate remains at 61%, unacceptably low. It seems that in some respects this may mirror the process we suspect is occurring with CTDP's: if they do not occur in accordance with the usual, widely understood, organizational routine, the risk exists that they may happen considerably late or in fact never occur. Thus, unless formalized and monitored, well-intentioned efforts can produce less than satisfactory results.

Related also to this notion of early intervention by Discharge Planners is the question of adequate staff clinical skill-mix, an issue we know DOHMH is attempting to address (see section III.h. above). In the absence of substantial clinical knowledge and training, discharge planners will be limited to performing more routine tasks such as prescreenings. In the absence of guidance from the clinical staff, and without the CTDP and DSN, they will not be able to assimilate the findings contained in the mental health screening, the psycho-social evaluation, and the psychiatric evaluation. Until the plans to change the skill-mix and scope of

[29] Our discussion with a discharge planner at BBKC leads us to believe that this acceleration of the prescreening timeline (i.e. doing the prescreening at the time of the Mental Health Assessment, rather than waiting for the CTDP) is a wise adjustment of the timeline. By the time the Class Member has the CTDP done, the prescreening has been completed and the discharge planner can proceed with implementing the recommendations of the prescreening.

responsibility for the discharge planners is fully implemented, the case conferences which we are given to understand are occurring in the various buildings, may serve as the bridge between the mental health staff and discharge planners in this regard.[30]

In our Third Report, we made a number of assumptions to conclude that there was a 73% compliance rate for this task based on the reported number of prescreenings done at HRA. We will mirror this process here. HRA reported that a total of 1572 prescreenings received from Correctional Health Services: 1111 were completed between February 1 and April 30, 2004 and 461 were incomplete and were returned. We are not clear as to the correct denominator to apply to this number.[31] Presumably, it represents all prescreenings done on all Class Members who required it during this time period. Using a similar calculation to that used in the Third Report, we find that 2226 of 3327 Class Members released during the relevant time period remained incarcerated for at least 23 days and therefore, in theory, should have been eligible for a

[30] This comment should not be read to imply that we believe that this is the **only** utility of these case conferences. We believe that these joint conferences are helpful in the implementation of necessary discharge planning, both because accurate data is available to the discharge planners and because a culture of collaboration is fostered.

[31] Defendants, in their written response, noted that "It is not possible to give an appropriate denominator for this particular data set. This data was not based on unique clients but rather was a production report of actions performed by HRA within a particular time frame. Future data reports by the Defendants will follow the reporting format outlined in Appendix 3, and will enable performance to be measured against a specified denominator." We note that this is the first time that we have been given this information regarding this task. We look forward to Defendants' future reports that include adequate information on which to judge their performance.

prescreening.[32] At this level, 1111 of 2226 or 50% of eligible Class Members had prescreenings done. Assuming that 24% of Class Members refuse discharge planning services, the denominator can be adjusted to 1692, raising the compliance rate to 66%. Further assuming, as we did in the Third Report, that 10% of Class Members are referred at a later date, and dropping these from the denominator, the compliance rate rises to 73%. There is no data from HRA regarding the timeliness of completion of the prescreening.

In our Third Report, we concluded:

> "[I]t is unacceptable to have to base this or any finding on the kinds of assumptions posited above. Secondly, 73% is an unacceptable compliance rate for a task as basic and straightforward as the Medicaid prescreenings. We are hopeful that the introduction of a reliable, accurate and complete database will assist us in refining the analysis and minimize the need to make these types of assumptions."

We conclude (1) that much work must be done to improve compliance with the prescreening process, which on the surface appears fairly simple and straightforward; (2) Defendants must explore the reasons for systemic noncompliance; and (3) work must be done to enable us to understand the variance between the two reporting mechanisms for this task (and all other

[32] Defendants, in their written response, noted that it is inaccurate for us to assert that 2226 Class Members, because their length of stay was >23 days, should have had prescreenings done, in part because not all inmates with mental illness are identified at the beginning of their incarceration. This is why we use the term "in theory". We use this number as a ceiling. We request of Defendants that they provide us with some information regarding the timing of the M designation, or of Class Membership timing, vis-à-vis the date of incarceration.

tasks) that involve more than one Defendant agency. The introduction of a more reliable, valid and internally consistent data reporting system indicates a markedly lower compliance rate on this relatively simple task.

Defendants reported the following outcomes of the prescreenings:

Summary of reported data regarding Medicaid prescreening for Class Members in jail, February 1, 2004 through April 30, 2004[33]

Task	N	%
Number of prescreenings completed	1572	
Number rejected[34]	461	29%
Number found with still active Medicaid	398	25%
Number active, needing and given recertification	31	2%
Number requiring reactivation and reactivated	376	24%
Number needing Medicaid applications	306	19%

A separate data set, on all Class Members for whom the prescreening was done during the reporting period (regardless of timing of M designation) indicated that:

Outcome	N	%
Active/reactivate	414	37%
New application	203	18%
Refused	53	5%
Submitted	1	0%
Unknown	441	40%
Total	1112	

[33] Note that these percentages do not represent Defendants' performance but rather describe the overall picture of the outcomes of the prescreenings done by Defendants.

[34] Prescreenings are rejected for the following reasons:

- the Class Member's Social Security number was inaccurate or was missing from the prescreening form,
- the Class Member was not being released from incarceration in that same month,
- the Class Member had no projected release date (and, therefore, was ineligible to receive Medicaid benefits), or
- the prescreening form had information missing or was illegible.

Regarding specifically the second bullet point, we do not believe that these prescreens should be included with other "rejected" prescreens. Rather, these prescreens should result in a finding of "release date too distant for reactivation, Class Member (1) otherwise eligible for reactivation or (2) ineligible for reactivation, needs new application." We request that in the future, this group be reported separately from other rejections.

In this data set, unknown indicates three possible responses on the part of HRA. First, a percentage of these contained either an inaccurate or absent social security number. As this is the unique identifier used by HRA, they are unable to process the prescreening without an accurate Social Security number. Another group consists of those prescreenings for whom DOHMH has not received a response from HRA. A third percentage includes those Class Members with no known or projected court or release date. This information is required by HRA as they cannot provide Medicaid to incarcerated individuals and thus require a projection regarding when the individual will no longer be incarcerated. For this purpose, they are willing to accept a court date as a projected release date. It is our understanding that data regarding projected release dates and court dates is dumped directly on a daily basis from the IIS into the DOHMH MIS. We would like to explore with Defendants how often this information is successfully entered into the IIS and then dumped into the MIS for use by discharge planners when performing the prescreening task.

These findings are very consistent with prior findings, in terms of the relative rates of the various outcomes of the prescreening process. It is apparent that Class Members have a high rate of Medicaid history and activity and that many of them are rapidly eligible for continued Medicaid benefits upon release.

Defendants also reported results of prescreenings completed at SPAN. A total of 139 Class Members visited SPAN during the reporting period.

Defendants indicate that the reporting period for the SPAN data differed slightly from the reporting period for the HRA data, explaining the slightly different number of prescreenings.[35] However, it is clear that all, or nearly all, Class Members who visit SPAN receive this service, which we find very encouraging. However, this raises the question regarding SPAN's receipt of information about discharge planning tasks completed within DOC – plausibly, jail-based staff should have already completed prescreenings for at least some of these SPAN visitors while they were in custody. If SPAN received timely access to mental health charts and timely access to an MIS system containing all of the information available given the stage of the Class Member's discharge planning at the time of release, it seems to us that this task as well as many others could be completed in a more efficient and effective manner.[36]

[35] We are hopeful that Defendants will be able to provide complete and coordinated data from all Defendant agencies for our future reports.

[36] Defendants note that SPAN is conceptually designed to provide services for Class Members whose services were not completed while they were incarcerated, and that as a result " . . . the absence of complete information in the database for SPAN clients is neither deficient nor inappropriate." We agree with this statement of purpose regarding SPAN as well as the assertion that if Class Members are coming to SPAN to appropriately complete tasks which were not completed in jail, the database will by definition be in those circumstances incomplete. We note several related points however. (1) This assumes that the appropriate cohort of Class Members is arriving at SPAN overall, i.e., those for whom the process **could not** be completed in jail, as distinct from those for whom it simply **was not** completed in jail. (2) On some of our site visits to SPAN, staff reported to us technical difficulties in accessing the MIS data-base. (3) Fields may quite appropriately be lacking information because of the stage of the discharge planning process at time of release, but our review and the report of SPAN staff indicates that it is not uncommon for the MIS to lack information which should have been present, given the state of the Class Member's discharge planning in the jail. (4) We make this comment in the context of timely availability (or more frequently lack thereof) for SPAN of medical records from jail-based providers. The MIS and the information contained therein takes on a heightened degree of importance when the chart is not available quickly than it would in cases where it is.

Summary of reported data regarding Medicaid prescreening for Class Members by SPAN, February 1, 2004 through April 30, 2004

Task	N	%
Number of prescreenings completed	142	
Number rejected	3	2%
Number found with still active Medicaid	69	49%
Number active, needing and given recertification	1	1%
Number requiring reactivation and reactivated	36	25%
Number needing Medicaid applications	33	23%

The outcomes are fairly consistent with earlier numbers, with somewhat more SPAN prescreenings resulting in a finding of still active Medicaid and somewhat less with an outcome of reactivation or need new application. Again, it is evident that Class Members have a high rate of prior Medicaid use.

g. Medicaid applications and the Medication Grant Program: DOHMH reported that 45 (41%) of 109 Class Members in need of a new Medicaid application had this done within the overall 5 day timeline (we have collapsed, for simplicity, the consecutive 3 business day and 2 business day timelines) during the 1/15/04-4/15/04 reporting period. HRA has reported that a total of 157 applications were received during an overlapping time period (2/1/04-4/30/04). As noted above, a total of 306 jail prescreenings resulted in a finding of "need new application". It is not clear to us why there is a substantial variance between this prescreening finding and the actual number of applications completed.[37] In our view,

[37] Some of this variance may be related to the differing time period for the data reported. Another portion of the variance may be due to the way data points were ascertained: HRA reports on all services it provided or acted on during its reporting period, while DOHMH provides information on services provided only to those Class Members who received an "M" designation during the relevant reporting period. We are

the correct denominator for calculating this compliance should be the 306 reported by HRA, and the correct numerator for the calculation should be the 157 reported by HRA. This results in a compliance rate of 51%. Of the 157 applications processed by HRA, 119 (76%) resulted in a finding of Medicaid-eligible, 23 (15%) of Medicaid-ineligible, and 15 (10%) were pending at the end of the reporting period.

A total of 21 applications were received at HRA from SPAN during this reporting period. Of these, 12 (57%) were found to be Medicaid-eligible, 2 (10%) Medicaid-ineligible, and 7 (33%) were pending at the end of the reporting period. However, 33 of the SPAN prescreeings resulted in a finding of need new application. As above, we have concerns about the 12 cases in which there was no application received at HRA. It is our understanding that, because a prescreening routinely takes 1-3 days to be completed, they do not wait for this when a Class Member requests Medicaid during their initial SPAN visit. Instead, they complete the prescreening form and fax it to HRA, but rather than await its routine return, they contact the Brad H unit at HRA and ask what the Class Member's Medicaid status is;[38] if the Class Member requires a new application, they immediately begin the process of applying for Medicaid and arrange for an appointment for the Class Member to complete the process at a Medicaid office.

hopeful that the use of an integrated report will provide a unified set of data that is more clear, coherent, comprehensive and comprehensible.

[38] Given that 75% of prescreenings from SPAN return with either "still active Medicaid" or "reactivate Medicaid" (see above), this step is clearly necessary and appropriate.

A separate data report indicates that a total of 193 Class Members received Medicaid during the reporting period. This data was provided in a vacuum. Other than a clarifying statement from DOHMH that this reflects data on the entire group of Class Members during the reporting period, and not just to those designated M during the reporting period, it is not clear to what group this data applies – jail inmates, SPAN clients, or a combination. Defendants indicated in their written response that they will work toward providing us with a single, integrated, and comprehensive data report in the future.

Paragraphs 70ff describe the MGP process and indicate that a subset of Class Members thought to be eligible for Medicaid but for whom Medicaid has not yet been activated or reactivated by the date of release should be provided with an MGP card. DOHMH reported that 14 Class Members were eligible to receive a Medication Grant Program (MGP) card. Three of them received this card on release (21%). A separate data request of DOHMH revealed that a total of 89 individual Class Members were enrolled in MGP during the reporting period, and an additional 48 Class Members who visited SPAN were enrolled in MGP. The reason for the marked difference in the first and second reports is not clear to us, though some of it may relate to the selection process used by Defendants for the first group (which included only those Class Members given an M designation during the reporting period).

Conclusions regarding compliance with MGP provision depend on finding an appropriate denominator. For jail-initiated compliance rates, the appropriate denominator would appear to be "Class Members with a pending application for Medicaid".[39] According to data reported above, this number is 15 (in the restricted population of those designated M during the reporting period). If 3 of this group received MGP cards, the compliance rate is 20%. This is acceptably close to Defendants' report of 3 of 14 individuals (21%) receiving a card upon release and raises concerns regarding this low compliance rate on what would appear to be a simple task.

[39] Defendants, in their written response, object to our characterization of the appropriate denominator on which to judge performance with regard to the provision of MGP cards. They provide the following list of reasons why a Class Member might not be provided with an MGP card:

1. Not incarcerated long enough to allow enrollment in MGP
2. Refused all discharge planning services
3. Not eligible for Medicaid
4. Has Medicaid with surplus
5. Illegal alien status
6. Has active Medicaid status upon release
7. Medicaid application cannot be submitted within 7 days of release
8. Class Member not on medication at time of release
9. Under the age of 18
10. Will be transferred to State custody or to a hospital and not released to the community
11. Released from court rather than jail and does not appear within 7 days of release at a SPAN office, unless SPAN can verify that a Medicaid application was submitted within 7 days of release

We recognize that there are reasons why an individual Class Member might not be eligible for this service. We believe, however, that our suggested denominator takes into account items 1, 2, 3, 4, 6, 7, and, in part, item 11. We understand Defendants' assertion that Class Members not on medication are not eligible for MGP. Regarding item 11, we agree that, if SPAN cannot verify that a Medicaid application was submitted, they would be obligated to complete and submit this application prior to providing a MGP card. However, this exception is irrelevant regarding the provision of an MGP card at the time of release. Finally, Defendants' MAP PROCEDURE 00-14(R1) DRAFT 11/20/03 states simply: "For Class Members who do not have active Medicaid coverage upon discharge, the DPP or SPAN office will submit the MGP application to the Pharmacy Benefits Manager (PBM) upon discharge." We believe that, at present, our suggested denominator is correct, given exclusions 5, 8 9, 10 and part of 11. We request that Defendants provide us with data regarding the number of cases excluded from the denominator on these bases.

For the other number of 89 individuals receiving MGP cards, the denominator is unclear. We would need information as to what number of Class Members had pending applications at the time of their release.

h. Public Assistance applications: DOHMH reported that 16 applications for Public Assistance were submitted to HRA within the collapsed 5 day timeline. They did not provide us with a denominator for this number. We believe that the appropriate denominator would be "SPMI Class Members who had a CTDP who did not refuse PA application".

HRA reported that 92 applications were "centrally registered" during this period, which we understand to mean applications that were received from inmates and detainees in the DOC. HRA indicated that they are unable to determine how many of the 92 individuals entered DOC prior to this reporting period (before 1/15/04) and so it is conceivable that some of the applications centrally registered were on behalf of inmates not in the DOHMH cohort. However, we have a difficult time accepting that 76 of the 92 applications received at HRA were done on Class Members who entered the system after 1/15/04. As we indicated in our Third Report, the data provided by Defendants regarding these applications was of only limited utility. Without adequate supporting information so we are unable to draw any conclusions regarding compliance. We believe that this reflects a poor coordination among Defendant agencies and further that this reflects inadequate data collection and reporting capacity on this issue.

i. Housing: According to DOHMH, of the members of this cohort who either had a CTDP done or had some contact with discharge planning personnel, 171 (13%) Class Members reported being homeless at the time of incarceration. At the time of release 185 (12%) of 1555 Class Members who had been incarcerated long enough to have a CTDP were homeless. Of this latter group, 63 (34%) were SPMI. 41 (22%) of the 185 homeless Class Members in this group had an HRA 2000 application submitted to HRA, 7 of whom (17%) were found eligible for supportive housing.

A subsequent data report from DOHMH indicated that in total, 149 HRA 2000 applications were done. This reflects a different cohort of Class Members, a cohort which is inclusive of all individuals receiving this service regardless of the timing of their M designation. For the 149 applications, DOHMH reported the following outcomes:

SPMI STATUS	Approved	Not Approved	CM Refused[40]	Unknown[41]	Total
LSPMI	18	5	3	48	74
Not SPMI			1		1
SPMI	10		1	45	56
Unknown	2	1	2	13	18
Grand Total	30	6	7	106	149

j. Transportation: DOHMH reported that of those Class Members with a completed CTDP eligible for transportation, 107 (14%) of 784 were *offered* that transportation. Regardless of CTDP completion, a total of 234

[40] This category includes those Class Members who refused this procedure **after** Defendants had completed the HRA paperwork; these applications were submitted.
[41] Defendants indicated that this category indicates "awaiting a response from HRA".

inmates with an M designation were "eligible" for transportation. The outcomes of these offers of transportation was as follows:

	RMSC	EMTC	Total
Eligible for Service	51	183	234
Accepted	3	66	69
Declined	45	117	162
Hospital Transfer	1	0	1
Turnaround	2	0	2

It is notable that a far smaller percentage of RMSC inmates than EMTC inmates accepted the offered transportation. While we do not have any particular hypothesis for this finding, we suggest that Defendants examine the finding and attempt to determine reasons for the differences between these two facilities. The information reported to us by incarcerated Class Members as to why they intended to refuse transportation is related to the delay incurred in waiting for the bus to arrive. While we understand that transportation may not be available instantaneously upon demand, we suggest that Defendants explore whether there are ways to reduce wait-time. It is quite possible that a reduction in wait-time would increase the utilization of this service. Further, we wonder if there are differences in the way in which this service is offered in the two facilities that might relate to the differential acceptance rate. We are not at this time suggesting that Defendants need do anything about this difference, but only that we work toward a full understanding of it.

2. Data from Monitors' Chart Reviews

a. Methodology

i. Chart Selection Method

We continued to utilize the chart-selection process previously discussed and described in our Third Report. The fundamental distinction between our practice currently and reported below is not in the selection procedure, but rather in the reporting of results. While our selection process continues to be to look at a weighted random sample, **we have *removed* from the statistical analysis outlined below any record which was reviewed for any not-entirely random reason.** One confounding variable is that, as described above at page 5, section III (b), mid-way through this reporting period we encountered the issue of having to seek releases from Class Members as a stop-gap measure. While the number was small, there were a very few Class Members whose charts were selected at random who refused to grant us the requested access to their protected information. We did not in these cases seek to employ an as-yet developed or agreed-upon redaction procedure, and, thus, those records evaded our review.

Our basic procedure is as follows:

1. The "Brad H. list" is a list of inmates with an "M" designation in the Inmate Information System ("IIS"). This daily report is

requested, or if that is unavailable, the most current available list is substituted. [42]

2. Cases are generally selected from among those Class Member incarcerated for more than 35 days and less than 75 days.
3. Cases are randomly selected for review having last names starting with different letters of the alphabet. Early in the reporting period, this was modified as follows: Selecting from the Brad H list, the reviewers identified every fourth, fifth or other interval depending upon the desired sample size; the reviewers then ascertained if the randomly selected Class Member met the length of stay parameters set in number 2 above. If this criterion (length of stay generally between 35 and 75 days) was met, the name was selected for review. This process continued until a sufficient sample size was obtained, taking into account the population size of the jail and the typical ratio of charts requested to charts obtained.[43]
4. Requests are made to include those residing on a mental observation unit and those in the general population.

[42] DOHMH recently informed us that up to six different reports are now produced on a daily basis by DOC from the IIS. DOHMH provided us with an copy of the types of reports available and we secured copies of the actual reports from the facilities. Although this may well be a positive development over the course of time, allowing staff to better manage their caseloads and reduce the likelihood of losing track of Class Members, in the short-term they have engendered some delay in our chart-selection process as the list produced for us currently does not include the date of incarceration.

[43] As noted, from time-to-time this is not the case when we look at the chart of a specific Class Member who has come to our attention either from the Plaintiffs' reports or by the Class Member him or herself initiating contact.

5. The list generated is handed to the clerk in the records room with a request for "any six" or some other number which are available at that particular time.
6. At SPAN (see section IV. b. below) the selection was purely random as charts were removed from the file cabinet without any selection process.[44]

Factors which may cause the sample to be less than fully random include:

1. an occasional response to an issue raised by Plaintiffs in their monitoring memos (there is one such case in the sample on which this report is based);
2. follow-up chart review on the occasion where a Class Member requests to speak with the Monitors or their clinical social worker;
3. the unavailability of what we estimate to be 40% of the charts we request at that particular time (this may be random in nature, or there may be some selection process involved which has an effect upon the availability of certain Class Members' records). As noted, the charts discussed in numbers 1, 2, 3 above were excluded from our numerical analysis of the results.

[44] We did have a SPAN staff member review charts to determine if HIV information was contained therein; if so, we did not review that chart. Thus, these were not completely randomly selected charts.

It should also be noted that the Monitors have initiated, and will continue to develop internal checks on quality and inter-rater reliability as they assess a sample of the charts reviewed by the clinical social worker and the data he reports from them.

ii. Review and Supervision Process

The majority of the chart reviews are performed by Jerome Marton, the social worker we retained as staff for this function, although some were reviewed jointly and in depth with the Monitors. He spends 2-3 days a week in jails, meeting with Class Members and reviewing clinical records. He also spends a day a week visiting a SPAN office, where he reviews records, and where possible, observes SPAN staff working with Class Members.

We hold regular supervisory meetings and conference calls with Mr. Marton. In addition, he provides us with weekly reports regarding his chart reviews and Class Member interviews. As specific issues arise, we review them with him and determine the best way of handling them. Examples of such issues have included:

- access to jails
- access to clinical records (especially with the confidentiality ruling)
- operationalization of the SPMI criteria

We have also, on occasion, accompanied Mr. Marton on his field visits. During these visits, we have observed and participated in informal staff interactions and chart reviews.

iii. Sampling and Randomization

In a meeting on April 28, 2004, we reviewed with DOHMH a proposal regarding an appropriate sample size to ensure adequate randomization and power to determine Defendants' compliance with all aspects of the Stipulation. We have not yet retained a statistical expert capable of assisting us in this effort and will defer decisions on statistical work until we have been able to do so. In the interim, we will continue to perform random chart reviews as per the above method.

b. Monitors' chart reviews: Our chart reviews included a total of 113 charts reviewed that were selected at random from the jails we visited (which included AMKC, RMSC, EMTC and OBCC) during this reporting cycle. Other charts were reviewed for specific reasons, including Class Member request, Plaintiffs request or for our own internal reasons, but these charts are not included in the following data analysis. The copies of this Report forwarded to the Parties[45] contains a confidential Appendix 5 identifying the Class Members whom we reference by number in connection with our chart review findings.

[45] This appendix is blank in the copy forwarded to the Court in order to protect the identity of specific Class Members and their confidential information.

c. Medical Assessment: This continues to be an area in which Defendants achieve a high degree of compliance. Of the 113 charts reviewed, 111 Class Members had the medical assessment within the required time. One client was in court and had the assessment done on day 2 after her admission; she is excluded from this analysis. The last chart (144) did not have any evidence of a medical assessment. Thus, on this measure, Defendants have achieved 99% compliance. Given Defendants' high rate of compliance with this step in the assessment process, we will only continue to monitor this step intermittently and by random chart review. In addition, we have removed this from Performance Indicator 1.

d. Timing of Initial Mental Health Assessment. Defendants are required to conduct the initial mental health assessment within 72 hours of the referral. Our reviews indicate that in 100 of the charts, the assessment was done within the required time. In one chart (176), it was unclear on which date the referral was made and so we are unable to determine if it fell within the timeline or not – for this analysis, this chart will be **dropped from the numerator and the denominator**. In one chart (281), the Class Member was in court on days 1-3 after the referral and the assessment was done on the first available day during which he was not in court. This raises the question as to why the assessment could not have been attempted during evening shift, when, to our knowledge, mental health staff are available in most jails. However, assuming that this Class

Member was truly unavailable to mental health on the days he was at court, we will **add him to the numerator** as meeting the required timeline. One case (226) was referred to mental health for this assessment, upon which mental health made two attempts on days 1 and 4 to complete the assessment; she refused both attempts. Several weeks later, on day 25, she became suicidal and an assessment was finally completed; she was admitted to the MO. Because of her refusals, this case will be considered in compliance, as she was assessed and referred to the MO when her condition deteriorated. In one case (172), the initial mental health assessment was done 14 days after the medical screening, but we were unable to locate a referral or consultation for a mental health assessment. It was not clear to us from the medical screening whether a mental health assessment was requested. We will include this case in our analysis as a late assessment. In one case (109), the mental health assessment done 2 months after intake indicated that DOC had made the referral but we were unable to locate the DOC referral form and therefore cannot determine the timeliness of this assessment; this case will be **dropped from the denominator**. Finally, one case (144) did not have a medical assessment (see above) nor any mental health assessment information at the time of our review and will be considered late. Thus, we find that the mental health assessments are done within the required time to a 92% compliance rate.

e. Presence of LSPMI form. Twenty four of 110 charts (22%) did not contain the LSPMI form. Of the remaining three charts in our random reviews, one (279) was found at the time of the mental health assessment not to be a Class Member and will be removed from this and all further analyses. Thus, we find that on this measure, Defendants achieve 78% compliance.

One of these cases (286) was rather disturbing and warrants a detailed discussion. He was incarcerated on 2/18/04 and seen by mental health upon referral on 2/25/04. Upon this evaluation, no further mental health treatment was recommended. He was re-referred on 3/31/04. A brief assessment was conducted with a recommendation for a psychiatric evaluation. We discussed this with the supervisor during our 4/6/04 chart review in the jail and were told that the evaluator "meant to write that no further mental health intervention was needed." We interviewed the Class Member through an interpreter, as he does not speak English, and he described auditory and visual hallucinations. The mental health notes are silent as to whether an interpreter or Spanish-speaking clinician was involved in either of his prior evaluations.

Of the 86 charts we reviewed that contain a LSPMI form, we determined that 59 were done adequately – i.e. they were completed fully and appropriately in a way that reflected and was consistent with other clinical documentation that would have been available at the time the form was done. In large part our assessment of this measure requires our

combined clinical expertise over many years in applying the criteria outlined in the State OMH SPMI definition (or similar criteria).[46] Examples of forms that do not meet our definition of "appropriate" would include cases in which an assessment form lists a GAF score <50 but for whom "no" is circled on item 2c, or an individual who requires MO housing and who is noted to be unable to care for personal hygiene needs for whom "no" is circled on item 2b. Our definition of "fully and appropriately" would include those Class Members on a Brad H. medication to treat a psychiatric condition, who are classified as LSPMI, absent a definitive clinical determination to the contrary.[47]

Our finding is that 59 of the 86 forms were done adequately (68%). Of the 110 charts which should have had a LSPMI form done, only 54% had an adequately completed form present in the chart.[48]

f. CTDP timeliness.

[46] An additional unresolved issue is the question of how to classify adolescents who are by definition precluded from receiving the SPMI classification because of their age (under 18). We recommend that the Parties discuss an acceptable way of handling those Class Members who are under 18 but otherwise meet the functional and clinical criteria for SPMI status. We further request that the Parties report to us the conclusion of their discussions. As with other issues, we remain favorably disposed towards assisting the Parties in reaching a reasonable and fair resolution to this issue. By way of initiating a discussion of the issue, we point out that their already exists an analogue to the SPMI designation for adolescents, that of Seriously Emotionally Disturbed ("SED").

[47] We recognize that while Class Members should initially (in the absence of concomitant clinical evaluation to the contrary) be classified as LSPMI based upon the prescription of a medication on the Brad H list for psychiatric reasons. We note that this designation is properly the subject of clinical assessment pursuant to the LSPMI form. We also recognize that Class Members may be determined to be not LSPMI even if on Brad H medications if reasons for this determination are explicitly included on the LSPMI form.

[48] We experienced some initial confusion, as to how we rated Class Members who were identified as LSPMI or not LSPMI based on a diagnosis of substance induced mood or psychotic disorder. Upon review, it is clear to us that such individuals would *not* be LSPMI if a substance induced mood or psychotic disorder is the only psychiatric diagnosis. We revised our calculations provided in the draft report to reflect our current understanding of the proper classification for such Class Members.

i. MO residents: a total of 46 of the cases in our random selection resided on an MO at the time of our review. Of these cases, 26 had the CTDP done within the required 7 day time period. Ten more cases had the CTDP done within 15 days. Within this latter group, 6 were housed on MO and should have had the CTDP done within the 7 day period. These six cases (216, 257, 259, 274, 141, and 200) had their CTDPs done on days 8, 8, 12, 12, 14 and 15 respectively. The other four cases broke out as follows: cases 157 and 260 were housed in GP at the time of the CTDP (on day 12 and 13 respectively) and will be analyzed as part of the GP group. Case 220 was admitted to GP, transferred to MO on day 15 and had the CTDP done on day 15. This case will be moved to the GP analysis. Case 208 was admitted to GP, transferred to MO on day 8, and had the CTDP done on day 14 (day 6 of MO stay). This case will be considered timely. Two more cases (170 and 201) were on GP at the time of the CTDP and will be moved to the GP analysis.

Thus, there are 41 cases for the MO analysis. Of these 27 (the 26 indicated above, and case 208) had the CTDP done in the required 7 days, for a 66% compliance rate.

Prison Ward Issues: The remaining cases raise a number of issues that can only be discussed by describing each case. One case (132) spent significant periods of time hospitalized on a prison ward, interfering with jail-based timelines. This individual was hospitalized at Elmhurst

for 8 days prior to entering the jail system, then spent 11 days in jail before returning to Elmhurst, then spent 9 days at Elmhurst and finally returned to jail. She had her CTDP done on day 26 after her initial jail intake and on day 7 after her second return from Elmhurst. Our data is unclear as to whether she was initially hospitalized on the prison ward at Elmhurst (i.e. her date of intake would be the date of the hospitalization), or whether her "incarceration" began at the time of her actual jail intake, or if it occurred sometime during her first hospitalization. This case underscores the importance of determining Defendants' responsibility to provide discharge planning required by the Stipulation to residents of the three prison wards. While we are reasonably certain that the staff on the prison wards are required by hospital licensure and accreditation requirements to complete a treatment plan that could serve as a substitute or functional equivalent for the CTDP, our real concern here is that the discharge planning system is structured in such a way that the CTDP drives future discharge planning efforts and that, without it, discharge planning does not begin until the Class Member is transferred to one of the DOC facilities. It is not clear to us that the hospital based treatment planning process includes an equivalent of the Discharge Service Needs ("DSN") form, which translates the clinically-based treatment needs into a clearly articulated formulation of the Class Member's post-release needs. Furthermore, if any community oriented discharge

planning efforts do take place while the Class Member is hospitalized on the prison ward, it is not clear to us how or if information regarding these efforts is transmitted to the jail-based discharge planners. While this issue certainly affects only a small number of Class Members, we reiterate that it is of great concern because this group from a clinical perspective is likely to include the most seriously impaired Class Members, and therefore those most in need of discharge planning services.[49] From an operational vantage point they represent a portion of the group we posit are likely to cause disruptions in the usual tracking mechanisms. Therefore, we consider both of these cases to be out of compliance with required timelines and again request clarification from Defendants regarding the provision of discharge planning services for Class Members housed on prison wards. We strongly recommend that Defendants develop and implement a system to provide discharge planning services to such Class Members[50]. Pending an ultimate mechanism to provide for this, we suggest that Defendants either (1) direct hospital-based social workers to perform the functions of the jail-based discharge planners during the period of

[49] To our knowledge, inmates are, as a general matter, transferred to the Prison Wards - which from a clinical perspective are units designed to treat acute conditions - for several primary reasons: they are actively suicidal; they are acutely psychotic in need of the complex level of treatment of an in-patient unit; they have a serious mental illness and will be more accepting of treatment in the hospital environment; they are severely depressed; they require a competency or other court-ordered examination be performed in an in-patient setting. With the exception of those undergoing a court-ordered evaluations, all of these categories indicate a level of acuity signifying patients at the highest risk.

[50] We make this recommendation, based on our belief that individuals housed in prison wards are Class Members and are due all services due to Class Members within DOC settings, in the absence of any agreement by the Parties or contrary direction from the Court, either of which we acknowledge would bind us to view this matter otherwise.

hospitalization, or, (2) post additional discharge planning staff, beyond those available in the jails, on the Prison Wards. In either instance, Defendants will need to develop a means of communication between the hospital and the jail-based staff.

The Parties have provided us with scant information regarding any efforts to resolve this issue. Defendants did inform us that they do not concede that people who are admitted to the prison ward directly from court without passing through a non-hospital jail facility are Class Members; we express no further opinion at this time in this regard except to request that this issue be resolved as quickly as possible.

The fact that one year into the remedial stage of this litigation the Parties are still contesting the composition of the class is indicative of a lack of sufficient constructive communication between the Parties. This type of situation, of which this issue is a primary example, creates significant uncertainty and distraction for the Monitors. Class Counsel would have us make a determination regarding the Class composition and begin vigorous monitoring efforts so that we can report on what is viewed as an important area of non-compliance. Defendants, for their part, assert that any such determination is beyond the scope of our authority under the Stipulation and for us to do so would in essence constitute an inappropriate effort to extend our powers. They counsel that we await a resolution by the Parties of this matter and thus hold our duty to monitor as ordered by the Court in abeyance. This would

not strike us as an unreasonable approach, but for the fact that we raised this issue as early as our November, 17, 2003 in our Special Report,[51] and we have not received from either Party any cause for optimism that they will soon resolve this issue. While we are not convinced that the Parties are on the path towards resolving this or other like issues on their own, neither Plaintiffs nor Defendants has expressed much enthusiasm for allowing the Monitors to attempt to assist in a role akin to that of mediators or arbitrators. Nor do the Parties bring many of these matters before the Court for resolution. Thus, we as Monitors are placed in the position of either: (1) cajoling (without any visible result or genuine authority) the Parties towards reaching agreement resolving these matters on their own, while in the meantime abdicating what we see as our responsibility under the Stipulation to monitor compliance of these tasks; or (2) creating immediately our own, non-binding interpretations of the Stipulation, thus possibly creating the impression that we do not properly understand our role in this matter. We find these extremes to be untenable and thus chose a middle ground. We believe that our role carries with it some inherent authority to make decisions related to the monitoring of the Stipulation of Settlement. We fully acknowledge that the Parties may inform us that they have agreed upon an

[51] "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." (Monitors Special Report, November 17, 2003, Page 13.)

interpretation of the Settlement, and we, in the absence of contrary direction from the Court, would accept such an interpretation as binding. However, in the absence of direction from either source (the Parties speaking jointly, or the Court), we believe that a time can arise when it would be irresponsible for us to continue to ignore a particular area because the Parties cannot reach an agreement as to the meaning of the Stipulation (in this particular instance the composition of the Class). In such cases, after due notice and a standing offer to act as mediators or arbitrators, we plan upon making a good faith interpretation, based upon all the available evidence, the positions of the Parties and our experience, as to how to interpret or operationalize certain outstanding issues. To repeat, even after making such determinations, we would be pleased to promptly revise them should the Parties jointly inform us that have arrived at a different interpretation, or should the Court otherwise direct.

Given that there is as yet no clear direction on the issue at hand (the Class Membership status of individuals incarcerated on prison wards), at this time we consider such persons Class Members for our Monitoring purposes. In addition, regardless of how this issue is ultimately resolved, it appears to us indisputable that many or most of the patients on the three hospital prison wards are Class Members within the meaning of any reasonable definition and do not appear to

be receiving discharge planning in accordance with the Stipulation during the time of their hospital stay.[52]

Movement between MO and GP: Case 207 involves a Class Member moving from GP to MO in the latency period between the first assessment and the CTDP due date. He moved from GP to MO on day 12 and had the CTDP done on day 18 (day 6 of the MO stay). Similarly, case 208 was moved to MO on day 8 and had the CTDP done on day 6 of his MO stay. For the time being, we consider these cases to meet the timeliness requirements (and recognize that case 208 meets the timelines in either case) but raise the concern that Class Members like this are among the more seriously ill – the very ones for whom delays in treatment and discharge planning can matter the most.

Case 259 refused mental health assessment on day 5 and eventually had his CTDP on day 12. As a refuser, this case will be dropped from the denominator.

In the final analysis, 29 of 39 (74%) of the MO Class Members met the timeliness requirement for CTDP completion.

ii. GP residents: a total of 72 of the cases in our random selection resided on in GP at the time of the CTDP. Seventeen of these cases did not have a CTDP on the chart at the time of our review. Of these 17, 4 (284, 138, 105 and 109) were reviewed prior to the due date. Two of

[52] In the near future, we plan upon testing the validity of this hypothesis during site visits to the various prison wards.

these (284 and 138) will be dropped from the denominator as they have not been reviewed after the timeline lapsed. The other two of these cases were re-reviewed at a later date: one (105) was found not to be a Class Member and will be **dropped from the denominator**; the other (109) had the CTDP done on day 18 and will be considered out of compliance for this analysis. Two cases (276 and 279) included documentation of refusal of mental health services and will be **dropped from the denominator**. One case (254) was determined at the time of the initial assessment to need no further services and will be **dropped from the denominator**. The denominator at this point is 66.

Of these 66 cases, 32 (48%) had the CTDP done within the 15 day timeline. One case (148) was "not produced by DOC" on days 14 and 15 and had the CTDP done on day 16– this case will be considered a timely completer for this analysis but we suggest that Defendants examine the process whereby Class Members are produced for services.[53] One case (149) refused mental health services on days 15, 22, 23 and 26 and finally had the CTDP done on day 27. As a refuser, this case will be dropped from the denominator. Thus, the final

[53] While one case does not represent a pattern, we would wonder whether we identified only one case because most medical records do not reflect "DOC did not produce patient" but are simply silent on the issue of no-shows. We suggest that DOHMH and DOC jointly examine this issue. As we note in footnote 12, it is DOC policy to have the ability to track this type of occurrence, and we believe that DOHMH policies similarly provide for the documentation of the reasons any Class Member is not produced for services.

analysis is that 33 of 65 (51%) of the GP cases reviewed were found to be in compliance with the CTDP timeliness requirement.

iii. Overall, 62 of 105 cases (59%) reviewed were in compliance with the CTDP timeliness requirement. The compliance was markedly better in the MO cases reviewed than in the GP cases, which is important given the relative illness burden and need for discharge planning among the MO Class Members. However, the overall rate of timely completion remains low, and our reviews are remarkably consistent with data provided by Defendants. This represents a major problem, as the CDTP is, as we have previously stated, a quintessential "upstream" issue. Indeed it represents perhaps the single most crucial point at which post-release needs are matched to the current state of knowledge regarding the Class Member's clinical assessments and are communicated to the Discharge Planners. The CTDP, along with the Discharge Service Needs Form ("DSN") which is attached to it, represent in effect the marching orders for the discharge planners, both from the viewpoint of the delivery system and the Stipulation. Simply put, if appropriate CTDP's and DSN's are not completed by Mental Health staff and transmitted to Discharge planners in a timely fashion, a substantial number of Class Members will not receive clinically appropriate discharge planning.

iv. Of note, we conducted a separate analysis of CTDP completion, regardless of timeliness, and found that 94 of 113 charts reviewed

(83%) had a CTDP. This is consistent with Defendants' finding above regarding on time and late CTDP completion.

g. Discharge Planning Refusals: Our data on this issue is very limited due to the state of the medical record in this regard. For the purposes of this review, we consider any progress note or other documentation in the medical record identified as a discharge planning note as constituting a record that discharge planning services were offered to that Class Member. We found as follows:

	N	%
Total	102	
Accepted all DCP Services	25	25%
Accepted some DCP Services	9	9%
Refused all DCP Services	32	31%
Class Member was never offered DCP Services	36	35%

Twenty of the 32 records of global refusers either did not contain documentation regarding this refusal or contained inadequate documentation (most commonly a signed but otherwise blank declination form). The overall percentage of Class Members who refuse discharge planning services indicates some reduction from prior findings and is very consistent with data provided by Defendants. However, of great concern is the finding that the clinical record indicates that Defendants did not offering discharge planning services to more than 1/3 of this sample.

B. Monitoring of SPAN Services

1. Data from Defendants

Defendants provided us with data regarding the total number of SPAN visits over the reporting period. There were a total of 139 SPAN visits during the reporting period (which for SPAN data is February 1 through April 15, 2004). There were 28 visits by female Class Members (20% of the total). The proportion of female Class Members released during the reporting period, per data from DOHMH, was 24% (797 of 3327), so the relative utilization of SPAN does not differ markedly by gender. Of the 139 Class Members who visited SPAN, 45 (32% were SPMI), a proportion similar to that reported for Class Members in the jail setting (see above).

Defendants reported that 87 of 139 SPAN visitors (63%) indicated that they had been advised to use SPAN or been given SPAN information while in the jail. Seventy percent (97 of 139) of the SPAN visitors were noted to be mentally ill-chemical abusers (MICA).

Forty nine of the SPAN visitors (35%) indicated that they were homeless when they came to SPAN. Given that Defendants report that 185 of 1555 (12%) of Class Members released during the reporting period were homeless upon release, this indicates a fairly marked difference between the group released and those utilizing SPAN. It is possible, of course that Class Members who did not believe they were homeless at the time of release were in fact homeless, or became homeless, prior to visiting SPAN. Another possibility is that homeless Class Members are more likely to use SPAN.

Either way, it is clear that housing is a key issue for Class Members utilizing the services of a SPAN office.

SPAN referred a total of 21 SPAN visitors to the Department of Homeless Services ("DHS") Correctional Review Unit ("DHS-CRU"). Assuming that these were all homeless Class Members, this indicates that 43% of homeless SPAN visitors were referred to the DHS-CRU. We have no information regarding other housing options provided to these homeless individuals nor regarding any Class Members who may have refused the DHS-CRU referral. In addition, SPAN completed 15 HRA 2000 applications. It is not clear to us at this time what criteria were used by SPAN for determining for whom to complete these applications.

SPAN provided a total of 65 appointments for mental health services, indicating that 47% of the visitors received this service. 48 (35%) of the SPAN visitors were referred to substance abuse treatment. Additionally, 17 individuals (12%) were provided with medications via the CHS pharmacy procedure outlined in ¶54 of the Stipulation.

As in the Third Report, the data indicated that the majority of Class Members (98 of 139, 71%) who used a SPAN office were sentenced inmates. Again, as in the Third Report, we are struck by the high incidence of sentenced inmates using SPAN when only 24% (788 of 3327) Class Members released during the reporting period were released with a projected release date. While we recognize that some individuals were released at court, with sentence of "time served" and therefore are considered sentenced, and that

other Class Members are sentenced to short sentences which would make it impossible to complete discharge planning within the timeframe of their sentences, we continue to be concerned with the disproportionately high utilization of SPAN by sentenced Class Members[54]. If discharge planning is taking place as it is outlined by the Stipulation, these individuals, with projected or known release dates, should be the very ones least likely to require SPAN's services.[55]

It is notable that 12% of all SPAN visitors (17 of 139) attended a SPAN inreach session. SPAN reported that a total of 139 Class Members attended the inreach sessions in the jails during the reporting period. This would cause one to conclude that about 5% (139/2665 total releases during the relevant period) of the group of released Class Members attended such a session. This group of Class Members therefore is overrepresented in the SPAN visit population, indicating that the inreach sessions are useful and lead to increased use of SPAN.

According to data provided, there were no SPAN visits after 5 pm during the reporting period. In correspondence dated April 27, 2004, DOHMH requested of us a modification of SPAN hours of operation from their current hours of 10 am – 7 pm (8 pm in Manhattan) to revised hours of 8:30 am – 6 pm in all boroughs. As reason for this request, Defendants indicated that only

[54] We accept in principle that this could occur, but, like Defendants we have do not know how significant a factor this is. We continue to request data on the question of how many Class Members are sentenced to "time-served" and then released from court, and are, thus, inaccurately considered to have had a "known" release date. See above, Section III.d.

[55] We understand the need and at times the desirability of making SPAN available to these Class Members, but still, taken as a whole, believe this statement to be correct.

2 of the 450 visits to SPAN to date occurred after 5 pm. This is inconsistent, however, with raw data provided to us by Defendants for the Third Report (but which we did not report there), which indicated that 5 of the 157 visits during that quarter occurred after 5 pm.

We recognize that there are few visits to SPAN during evening hours, and are not suggesting that we would be averse to approving a revision in operating hours designed to better serve the population. However, until an internally consistent, valid and reliable data set can be provided to us that clearly demonstrates both unused SPAN time late in the day and a demand for SPAN time prior to 10 am, we will not approve such a change. We believe that, once active, multilingual public relations efforts regarding SPAN occur in the jails, there will be an increasing demand for SPAN's services. Further, it seems to us that this demand is unlikely to occur before 10 am and far more likely to occur later in the day. We request at this time the rationale behind DOHMH's implicit assertion that greater utilization will likely ensue between the hours of 8:30 am and 10:00 am.

2. Data from Monitors' Chart Reviews

A total of 35 SPAN cases were reviewed during this reporting period. Two Class Members were interviewed during their SPAN visit, and the remaining 33 cases were charts pulled randomly for review. Of the 33 charts reviewed, 3 represented individuals who either were not Class Members or who had served some time in the State of New York DOC between their incarceration in NYC DOC and their visit to SPAN. Another 3 charts

represented Class Members who visited SPAN outside of the 30 day window of opportunity outlined by ¶36 of the Stipulation. These charts have been excluded from subsequent analysis.

Our main focus of review for this report in our SPAN chart reviews was the receipt of records in a timely manner from the jail that released the Class Member visiting SPAN. We believe that in order for SPAN to effectively provide the services required by the Stipulation, the workers there must have access in real time to the Class Member's mental health records documenting treatment and discharge planning provided in the jail. In other words, if the record does not come on the day of the visit, and ideally within the 2 hours that SPAN generally has with a Class Member, it is not useful. As a backup on those occasions when a medical record does not come to SPAN in a timely fashion, access to the MIS system is a necessity at SPAN.[56]

For the 27 charts remaining in the analysis, records were requested and received as follows:

Received	N
Day of intake	8
One or more days after intake	14
Never	5

This data indicates that relevant and necessary clinical information is received at SPAN in a manner consistent with the nature of SPAN's work to be useful about 30% of the time. We recommend that Defendants re-examine

[56] We understand that SPAN has access to the MIS. However, during our site visits, we have been advised that on some occasions, there are technical problems with this access.

this problem and find a suitable mechanism remedy this state of affairs.[57] In the other cases, the information is received late or not at all, but the functional outcome is identical unless the Class Member returns for further discharge planning. We have previously been informed by Defendants that Class Members infrequently return for follow up visits.

Overall, we remain concerned about the low rate of utilization of SPAN services. We remain convinced that the development of SPAN offices represents a fundamental conceptual breakthrough indispensable to providing discharge-planning services to Class Members. We see a vibrant SPAN service as essential to the success of the essential goals of this Stipulation. As a result, we strongly recommend a sustained and intensive effort to enhance the rate of utilization of this important service. We repeat and emphasize the following:

1. SPAN brochures should be translated into common languages without delay.
2. Posters informing Class Members and their families should be posted in appropriate languages in prominent places throughout the clinics, housing and visit areas.
3. Our analysis reflects that SPAN in-reach significantly increased utilization rate and increases in frequency of these sessions should be considered.

[57] We have on numerous occasions suggested that a computerized, multi-user medical record would ameliorate this problem; other solutions might be possible, but the current situation is certainly counter-productive and inefficient. Related to this, we request of Defendants that they provide us with any policies and procedures related to the chart-request and forwarding process as well as related to any collection of data in this regard.

Additionally, SPAN should distribute written information and business cards with pertinent information at these sessions.

4. Ideally, SPAN would be located within the Criminal Court buildings. We are aware that the Stipulation does not provide for this and in the absence of this change we recommend the following:

   a. That Defendants explore again the possibility of notifying SPAN of the pending release from court of an inmate with an "M" designation in the IIS., thus permitting SPAN to attempt to meet and engage the Class Member who of course would not be held against their will in order for this to occur.

   b. SPAN should become more active and present in the Courthouses as provided for in ¶40.

We believe that this combination of efforts, in conjunction with additional and/or different efforts by Defendants, will improve the low rate of attendance for this service.[58]

IV. Current Recommendations

As noted above in Section II, we have laid out for the first time in a single place our prior recommendations, Appendix 1. This is done in a format that will allow

[58] Defendants in their response to our draft report point out that our hypothesis that increased SPAN utilization will occur if our suggestions are implemented is speculative and that therefore Defendants are not required under the Stipulation to take affirmative actions to increase SPAN utilization. Clearly, we accept that we do not know what the outcomes of our suggested actions, if taken, will be. However, they are based upon our knowledge of the population they are calculated to affect and are put forth after considerable deliberation on our part. Additionally, we do know that a greater percentage of Class Members who attend SPAN inreach sessions utilize SPAN than of those who do not attend the inreach. This suggests that the population is amenable to outreach, "marketing" efforts. The Stipulation is silent regarding additional actions to publicize SPAN offices. We make these suggestions knowing that effective use of the SPAN offices is essential to the provision of discharge planning services to a highly transient jail population who may be, and often are, released precipitously and without adequate opportunity for discharge planning to have occurred.

Defendants to provide us with feedback in a fairly straightforward manner regarding their progress on these measures.

In the same format, we have laid out in Appendix 6 recommendations based on our ongoing monitoring efforts. Some of these have been discussed in detail in the report, while others have been developed in our conversation with Defendants during the reporting period. This table should be added to the table included in Appendix 1 for a coherent and complete set of our recommendations to date.

V. CONCLUSION

This concludes our Fourth Report. Effective this report, all future regular reports will occur on a 120 day cycle, or three times per year, on or about October 6, February 6 and June 6. We will, as needed, produce interim reports.

We will summarize what we see as the main messages of this report.

A. We support the organizational, procedural and technological changes described in this report, as represented by Defendants, and we encourage their rapid and full implementation. We additionally support the focused attention DOHMH is currently bringing to bear on the numerous outstanding compliance issues we outline in this report.

B. As described in detail, we have focused on what we believe to be certain key tasks in the discharge planning chain of events. We have identified a number of areas in which Defendants continue to fall short. These include

   1. timeliness and completion of the CTDP
   2. completion of the Medicaid prescreening

3. completion of the Medicaid application
4. provision of appointments with and referrals to appropriate community mental health agencies
5. submission of the Public Assistance application
6. provision of transportation

C. Defendants are doing well in some areas, and especially those which have been longstanding aspects of service provision in the jails, including

1. Medical Screening
2. Initial Mental Health Assessments

In addition, we found that 76% of the charts we reviewed contained a LSPMI form. While we have concerns about the content of some of these forms, the presence of the form in this number of charts meets our expectations currently for this task.

D. Prior recommendations and several new recommendations were added. These are summarized in Appendices 1 (prior recommendations) and 6 (current recommendations). We request that Defendants provide us with regular reports regarding their progress on implementing these recommendations. In addition, we have provided a worksheet for use by Defendants and by the Monitors in keeping track of Defendants' performance on many of the key aspects of the Stipulation (Appendix 4).

E. Performance Indicators are being published with this report.

In closing, we thank the Parties for their continued cooperation and assistance with our monitoring efforts. Our next report is due on ***October 6***, 2004. Our next draft report

will be published on ***September 15***, three weeks prior to the due date of the report. All data for inclusion in the next report should be provided to us by ***August 25***, three weeks prior to the draft date and six weeks prior to the report due date. We encourage Defendants to automate to the extent possible the provision of this data to us on a regular basis, consistent with our prior requests and with refinements that are sure to come with further discussion.

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

Respectfully Submitted,

Henry A. Dlugacz

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Henry Dlugacz
Compliance Monitor

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Compliance Monitor