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

BRAD H., *et al*.,

Plaintiffs,

-against-

Index No. 117882/99
IAS Part 47
Justice Paul A. Goetz

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

Defendants.

FORTY-NINTH REGULAR REPORT OF THE COMPLIANCE MONITORS

June 30, 2022

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Forty-Ninth Regular Report of the Compliance Monitors
June 30, 2022

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 the provision of Discharge Planning in City Jails and defendants' compliance with the terms and provisions of the Stipulation of Settlement ("Stipulation[1]") resolving the outstanding issues in this cause.

[1] The parties executed an original Stipulation of Settlement on or about January 8, 2003, and an amended Stipulation on or about August 1, 2017. This report refers to these documents collectively as "Stipulation" qualifying them as "original" or "amended" only where it is required for clarity.

Contents:

Defined Terms and Acronyms Used in Reports

ACT	Assertive Community Treatment
A-List	List of programs providing a wide array of mental health services likely to meet the needs of many class members
AMKC	Anna M Kross Center
ANS	Assistance Network Services, a transitional case management program operated by CRAN
AOT	Assisted Outpatient Treatment ("Kendra's Law")
ATI	Alternative to Incarceration Program
BHPW	Bellevue Hospital Prison Ward
BOC	New York City Board of Corrections
Brad H. Medication	Antipsychotic and mood-stabilizing medications
C71	Mental Health Center located on Rikers Island
CAPS	Clinical Alternative to Punitive Segregation
CHARM	Correctional Health Access and Redaction Module
CHER	Defendants' current electronic health record, used in the jails
CHS	Correctional Health Services
CM	Class Member
CNYPC	Central New York Psychiatric Center
CQI	Continuous Quality Improvement
CRAN	Community Re-Entry Assistance Network
CTCM	Community Transitional Case Management, a transitional case management program operated by CRAN
CTP	Comprehensive Treatment Plan
CUCS	Center for Urban Community Services
DCP	Discharge Plan
DCPU	Discharge Plan Update
DHS	Department of Homeless Services, New York City
DOC	Department of Corrections, New York City
DOCCS	Department of Corrections and Community Supervision, New York State
DOH	Department of Health, New York State
eCW	e-Clinical Works, the EMR previously used by CHS
EHPW	Elmhurst Hospital Prison Ward
EHR/EMR	Electronic Health Record/Electronic Medical Record
EMTC	Eric M Taylor Center
FACT	Forensic ACT
GP	General Population
GPMED	Class Members housed in GP who are prescribed Brad H. medications
GPNOMED	Class Members housed in GP who are not prescribed Brad H. medications
GRVC	George R Vierno Center
H+H	Health and Hospitals Corporation, New York City
HRA	Human Resources Administration, New York City
I/A	Intake/Assessment Shelter
ICM	Intensive Case Management
IIS	Inmate Information System
IMT	Intensive Mobile Treatment
MA	Medicaid

MGP	Medication Grant Program
MH	Mental Health
MIS	Management Information System
MO	Mental Observation (Housing Unit)
NIC	North Infirmary Command
NYSDOH	New York State Department of Health
OBCC	Otis Bantum Correctional Center
OMH	New York State Office of Mental Health
OPWDD	Office for People with Developmental Disabilities
PA	Public Assistance
PACE	Program to Accelerate Clinical Effectiveness
PI	Performance Indicator
RMSC	Rose M Singer Center
RNDC	Robert N Davoren Complex
ROR	Released on Recognizance
SDOH	New York State Department of Health
SPAN	Service Planning and Assistance Network
SMI	Seriously Mentally Ill
SPOA	Single Point of Access (used to apply for case management and supportive housing)
SSA	Social Security Administration
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Insurance
SUD	Substance Use Disorder
SW	Social Worker (used for staff involved in discharge planning)
TASC	Treatment Accountability for Safer Communities, an ATI
TPR	Treatment Plan Review
VA	Veteran's Administration
VCBC	Vernon C Bain Center
WF	West Facility
WMS	Welfare Management System

I. Introduction

This constitutes the Forty-Ninth Regular Report of the Monitors. This report covers defendants' compliance with the Stipulation and orders of this Court for the reporting period of July through December 2021.

Background

This matter originated with plaintiffs alleging that defendants were violating the New York Mental Hygiene Law and the Constitution of the State of New York by failing to provide adequate discharge planning to inmates receiving mental health treatment in New York City jails. After the Court entered a preliminary injunction directing defendants to provide discharge planning to the plaintiff class in accordance with New York Mental Hygiene Law, this Court (Braun, J.) certified a Class consisting of:

> "all inmates (a) who are currently incarcerated or who will be incarcerated in a correctional facility operated by the New York City Department of Correction ("City Jail"), (b) whose period of confinement in City Jails lasts 24 hours or longer, and (c) who, during their confinement in City Jails, have received, are receiving, or will receive treatment for a mental illness; provided, however, that inmates who are seen by mental health staff on no more than two occasions during their confinement in any City Jails and are assessed on the latter of those occasions as having no need for further treatment in any City Jail or upon their release from any City Jail shall be excluded from the class" (Stipulation of Settlement, January 8, 2003).

Subsequently, the parties entered into the Stipulation under which defendants agreed to perform various tasks to provide clinically appropriate individualized discharge planning to the Class. The Stipulation provides for monitoring by two Compliance Monitors. Paragraphs 193 and 194 state that:

> "The provisions of this Agreement shall terminate at the end of five years after monitoring by the Compliance Monitors begins pursuant to § IV of this Agreement. Plaintiffs may apply to the Court by motion on notice for a finding that Defendants have not complied with the terms of this Settlement Agreement over the preceding two years, and, if such finding is made by the Court, for an Order continuing the provisions of this Agreement for an additional two-year

interval or intervals to the extent necessary to correct any current and ongoing violation of this stipulation.

"At the end of each such additional two-year interval, Plaintiffs may apply to the Court by motion on notice for a finding that Defendants have not complied with the terms of the Settlement Agreement over the preceding two years, and, if such finding is made by the Court, for an Order continuing the provisions of the Settlement Agreement to the extent necessary to correct any current and ongoing violation of this Settlement."

Meet and Confer Process: On July 29, 2020, class counsel filed their motion to enforce the Settlement along with a supporting memorandum of law. Following motion practice and briefing, this Court entered a Decision and Order on Motion on April 26, 2021, ordering that

"…the motion… of plaintiffs for an order continuing the terms of the stipulation of settlement dated January 8, 2003, as amended by stipulation dated June 6, 2017 and entered on June 13, 2017 is granted;

"…the terms of the stipulation of settlement dated January 8, 2003, as amended by stipulation dated June 6, 2017 and entered on June 13, 2017 are extended for a term of two years commencing from the date of this decision and order;

"…defendants are directed to comply with each and every one of their obligations under the stipulation of settlement, the court's April 18, 2014 decision and order, and the court's September 19, 2014 decision and order, including providing individualized, appropriate discharge planning and complying with each of the performance goals established by the compliance monitors;

"…that defendants are directed to implement a robust, transparent quality assurance system capable of identifying, reporting on, and ultimately reducing the error rate in defendants' data reporting;

"…that defendants are directed to fully staff all discharge planning positions;

"…that defendants are directed to provide the compliance monitors with access to class members' electronic mental health records;

"…that defendants are directed to ensure that discharge planning staff are part of the mental health treatment team in the general population;

"…that, within 45 days of the date of this decision and order, the parties shall confer in good faith with the compliance monitors concerning reasonable

modifications to the timing parameters and performance goal percentages;[2] and

"…that the cross motion of defendants is denied" (NYSCEF Doc No. 76 Motion #023). (emphasis added)

Since that time, the following progress has been made in response to the court ordered meet and confer process. By agreement of the parties and the monitors, a decision was made to focus first on potential modifications to the Stipulation's timing parameters. Only after it was clear what modifications the parties arrived at would we engage in discussions regarding the various performance goal percentages (thresholds).

4/26/21	Court order to confer "within 45 days…."
5/28/21	Plaintiffs contacted the monitors, on behalf of both parties, requesting to confer during the week of June 7. The monitors responded on that same date with dates available during that week.
6/2/21	Defendants provided their availability on June 11. Plaintiffs responded that they would be available "subject to obtaining leave of the court to extend the date by which the parties must meet and confer." An all parties' meeting was scheduled for June 11.
6/8/21	Defendants then requested to meet with the monitors only on June 11, with a subsequent meeting to include plaintiffs and the monitors scheduled for June 15.
6/9/21	Defendants wrote a letter to the court with plaintiffs' consent requesting "permission to conduct the required meeting no later than June 18."
6/10/21	45 days from the court order.
6/11/21	Defendants met with the monitors at defendants' request.
6/15/21	Early that morning, defendants provided an outline of their proposed modifications, which were discussed in the meeting with all parties present. At the conclusion, defendants agreed to provide the plaintiffs and the monitors with a more complete version of their proposals.
8/3/21	Defendants provided a more detailed proposal with respect to CHS' obligations.
8/16/21	Defendants provided a more detailed proposal with respect to HRA, DHS and DOC's obligations.
8/17/21	The monitors wrote to the parties inquiring as to the process they anticipated to move forward with respect to defendants' proposals.
8/20/21	Plaintiffs met with the monitors to discuss the proposals. After this meeting, plaintiffs wrote to defendants and the monitors indicating their plan to respond to the proposals "by the end of [the following] week."
9/13/21	Plaintiffs forwarded their written response to defendants and the monitors.
9/20/21	A meeting to include all parties was scheduled for October 1.
9/30/21	Defendants postponed the meeting "to attend to various matters relating to conditions at Rikers Island…." The meeting was reset for October 18.
10/15/21	Defendants postponed the meeting for at least two weeks "due to a number of emergencies and high priority matters involving Rikers…."

[2] In this report, the terms "performance goal" and "performance threshold" are synonymous.

10/21/21	The meeting was reset for November 8.
11/8/21	The meeting took place, and the parties and monitors began discussing the various proposals and counterproposals, starting with the proposed modifications to the Stipulation and continuing with proposed modifications to the performance measures and their attendant compliance thresholds.
11/15/21	A follow up meeting occurred to complete the discussion of proposed modifications to the performance measures.
12/10/21	Plaintiffs forwarded their written responses to defendants' proposals focused on the modifications to the Stipulation.
1/7/22	Defendants provided written responses to plaintiffs' responses to defendants' proposed modifications to the Stipulation. Plaintiffs indicated that they would draft a stipulation reflecting the agreed amendments.
1/21/22	Plaintiffs provided proposed revisions to the Stipulation.
2/11/22	Defendants emailed the monitors informing us that the parties had "…concluded [their] discussions concerning Stipulation amendments and are currently in the process of memorializing those changes in a revised Stipulation." That email also contained defendants' proposal regarding modifications to the performance thresholds along with several supporting documents.
3/5/22	Plaintiffs provided their written input as to modifications to the performance indicator thresholds.
3/11/22	After consideration of both parties' ideas as to the thresholds, the monitors forwarded a draft document containing the revisions we anticipated making to the thresholds. The monitors outlined a schedule for further input from the parties and finalizing the revisions to the PIs no later than April 21.
4/1/22	The parties and monitors met virtually to discuss the monitors' approach to the PIs and the revised thresholds based on that approach. The parties had opportunities to ask questions and provide their views. The parties were given one week to provide further written input, should they choose to do so.
4/7/22	Defendants requested an additional week to provide their input regarding the PI thresholds. The monitors indicated that this was acceptable but that this delay would result in a delay in finalizing the thresholds until early June. Defendants indicated that this was acceptable and that they would try to provide their input earlier. We so notified class counsel and extended the deadline for input from the parties until April 15.
4/14/22	Defendants provided their written input regarding the PI thresholds.
4/15/22	Plaintiffs provided their written input regarding the PI thresholds.
4/28/22	Defendants provided responses to plaintiffs proposed revisions to the Stipulation with a few suggested modifications.
5/31/22	Plaintiffs responded and posed some follow up questions to defendants.
6/3/22	Defendants responded to plaintiffs' queries.
6/16/22	Plaintiffs provided an edited version of the Stipulation.

Modified Performance Goals: Following the process outlined above, the monitors undertook a thorough review of the parties' respective positions concerning modifications to the performance goal percentages (PI thresholds). In conducting this review, which was

informed by the monitors' 68 years of combined relevant experience,[3] the monitors considered

- defendants' pleadings of September 17, 2020 made in connection to class counsels' enforcement motion with an emphasis on the affidavits and affirmations of CHS' leadership and defendants' retained expert (see, e.g., NYSCEF DOC NO. 29, 34, 36, 37, 38, and 39);
- the parties' verbal and written communications received during the process described above;
- the obstacles typically encountered in providing services in the correctional setting;
- the range of professional standards they have seen applied in large public mental health settings;
- performance thresholds they have seen employed in the court-ordered monitoring of such systems;
- performance expectations included in contracts with which the monitors are familiar related to the provision of mental health services in correctional settings;
- the relative level of importance placed by the parties on each PI; and
- references provided by defendants.

To structure their review, the monitors divided the PIs, which grew out of the 13 performance goals they were ordered to develop in ¶142 of the Stipulation, into three categories – Critical, Key, and Standard – each with an attendant performance threshold. The Stipulation had already culled those PIs from among the many more obligations defendants committed to, elevating those included in ¶142 to a high degree of importance in monitoring the Stipulation. The three categories are defined as follows:

Level of Importance	Description	Threshold
Critical	Matters of health and safety	95%
Key	Important tasks with downstream impacts	90%
Standard	Important tasks with minimal direct impact on other tasks	85%

[3] The monitors' relevant experience includes: developing, directing and monitoring multiple large public mental health systems in jails, prisons, and city- and state-hospital settings including the NYC jail system and across the country; developing, managing and monitoring quality improvement approaches within the above systems; providing services to people confined in those systems and following their release; training professionals in multiple disciplines who work in and monitor these systems; and their extensive experience monitoring the PIs required by the Stipulation of settlement in this matter.

In their submissions to the monitors, the parties also assigned levels of importance to the various PIs, though their categories were named somewhat differently, and they diverged as to the percentages that were assigned to each category. The parties assigned the same level of importance for eight PIs.[4] We assigned that level of importance in seven of those instances, differing only for PI 3.3, where we assigned a lower level of importance than either party, resulting in our adopting defendants' proposed threshold percentage.

The parties' assignment as to relative degrees of importance diverged on 13 PIs.[5] In 11 PIs, we assigned the same level of importance as class counsel, mainly because defendants assigned higher levels of importance than we did. As a result, in eight of these PIs, our threshold percentage mirrors that of defendants.

For 17 PIs, mostly related to tasks performed by defendant agencies other than CHS, defendants made no proposals.

This process resulted in our assigning 6 PIs to the Critical category, 19 to the Key category, and 13 to the Standard category. As shown below, the threshold was reduced for 30 PIs, unchanged for 5 PIs, and increased for 3 PIs (all related to facilitating class members' access to medications in the period following release when incarcerated people are a high risk for death, hospitalization, and rearrest).

- 14% reduction 2 PIs
- 10% reduction 7 PIs
- 5% reduction 20 PIs
- 4% reduction 1 PIs
- no change 5 PIs
- 5% increase 3 PIs

[4] These include PIs 3.1.2, 3.2 (supportive housing), 3.3, 7.1.1, 8.3, 9.2, 10.1, 10.2 and 3.2
[5] These include PIs 1.1, 2.4 (SMI assessment), 3.1.1, 3.2 (appointment/referral and case management), 4.1, 5.1, 5.3.1, 8.1, 11.1, 12.0.1, 12.0.12, and 12.0.2.

The revised thresholds are generally consonant with the information provided by defendants' expert as well as the authority cited by defendants with respect to national standards in monitoring and with the monitors' experience in the oversight of the remedial phase of class action litigations in the correctional setting. The PIs with the largest divergences between defendants' proposals and our determinations include PI 1.1 and the appropriateness measures, where defendants advocated an 80% threshold.

The modified performance goals are contained in Exhibit 1 of this report.

Data, Data Dictionary, Coding and Crosswalk

As discussed in detail in Section IV.B below and in recent reports, CHS had not provided the information needed to permit definitive compliance findings. On June 24, 2022, CHS provided an updated, redlined version of the data dictionary. We will review this as soon as possible during the coming reporting period. After the data dictionary is finalized, CHS will need to provide the underlying coding and the crosswalk that will allow us to make definitive compliance findings.

Compliance

Table 1: Compliance Findings, Report 49

Description	Agency	PI	Finding	Section	Chart Reviews	Defendants' data
Timely Activation of Medicaid	HRA	6.1	Compliant	IV.C		100.00%
Timely Unsuspension of Medicaid	HRA	6.2		IV.C		95.99%
Provision of Emergency Benefits	HRA	9.1		IV.C		100.00%
Processing and Pending of PA Applications	HRA	9.3		IV.C		100.00%
Direct Placement in Program Shelters	DHS		Tentatively compliant	IV.G		
Timeliness of Initial Assessment	CHS	1.1	Crosswalk and coding that are required to permit validation of data not provided: unable to demonstrate compliance	IV.C		68.41%
Timely Completion of Prescreen by ANS	CHS	4.1.2		IV.C		100.00%
Submission of MA Application	CHS	5.1		IV.C		68.54%
Submission of MA applications by ANS when prescreen was completed in jail	CHS	5.2.1		IV.C		100.00%
Provision of MGP Card on Release Date	CHS	5.3.1		IV.C		81.47%
Provision of MGP Card at ANS	CHS	5.3.2		IV.C		100.00%
Provision of Medications and Prescriptions upon Release	CHS	7.1.1		IV.C		85.91%
Provision of Medications by ANS-day of Release	CHS	7.1.2		IV.C		100.00%
Provision of Medications by ANS-after day of release	CHS	7.1.3		IV.C		100.00%
Provision of Appointments	CHS	8.1		IV.C		83.78%
Provision of Appointments by ANS	CHS	8.2		IV.C		100.00%
Provision of Referrals	CHS	8.3		IV.C		91.69%
Submission of PA Application	CHS	9.2		IV.C		57.37%
Submission of HRA 2010e Application	CHS	10.1		IV.C		80.56%
Forwarding of Supportive Housing Approvals	CHS	10.2		IV.C		100.00%
Provision of Transportation	CHS	11.1		IV.C		100.00%
Provision of Transportation by ANS	CHS	11.2		IV.C		100.00%
Follow-up contacts re: Appointments	CHS	12.0.1		IV.C		51.43%
Follow-up contacts re: Referrals	CHS	12.0.12		IV.C		89.92%

Table 1 (continued): Compliance Findings, Report 49

Description	Agency	PI	Finding	Section	Chart Reviews	Defendants' data
Follow-up contacts re: Housing	CHS	12.0.2	Crosswalk and coding that are required to permit validation of data not provided: unable to demonstrate compliance	IV.C		79.12%
Offer of assistance re: Housing	CHS	12.0.3		IV.C		0/0
Follow-up contacts re: Appointments by CTCM	CHS	12.1		IV.C		100.00%
Follow-up contacts re: Referrals by CTCM	CHS	12.2		IV.C		100.00%
Follow-up contacts re: Housing by CTCM	CHS	12.3		IV.C		100.00%
Offer of assistance re: Housing by CTCM	CHS	12.4		IV.C		100.00%
Timely release of Parole Violators	DOC		Incomplete data: unable to demonstrate compliance	IV.I		
Timeliness of CTP	CHS	3.1	Tentatively noncompliant	IV.C	54%	61.37%
Timeliness of CTP - MO	CHS	3.1.1		IV.C	61%	91.18%
Timeliness of CTP - GP	CHS	3.1.2		IV.C	43%	53.47%
Timeliness of DCP	CHS	3.3		IV.C	60%	76.77%
Timely Completion of Prescreen	CHS	4.1.1		IV.C	61%[6]	97.53%
Appropriateness of SMI assessment	Monitors	2.4	Noncompliant	IV.D	92%	
Appropriateness of Appointment/referral	Monitors	3.2		IV.D	50%	
Appropriateness of Case Management	Monitors	3.2		IV.D	66%	
Appropriateness of Supportive Housing	Monitors	3.2		IV.D	50%	
Time of Release	DOC			IV.H		97.33%

[6] In their comments to the draft of this report, defendants pointed to "OHIS Medicaid Information Templates" in the medical records that indicated a timely prescreen in a few of these cases. We again reviewed these cases and do not find any such templates in the records provided to us. We do find, instead, documents titled "MH – Social Work – Medicaid Application" templates in which SW completes a prescreen that identifies the class member's current Medicaid status. Going forward, we will consider the OHIS templates should they be included in the records provided for our review.

State of Crisis

As an ongoing sequela of the COVID emergency described in previous reports, it is common knowledge that the New York City jail system is in a state of crisis, both by exacerbating existing problems, and by creating new problems. CHS currently reports that:

> "COVID-19 continues to complicate the provision of mental health and social work services within the jails, both directly, as subsequent waves of transmission pass through, and indirectly, due to baseline COVID-19 control measures which complicate the logistics of care delivery. Most recently, the Omicron variant led to high case rates in December to January 2021/22 and required extensive isolation and quarantine operations across all facilities. Even in times of limited transmission, such as February through March 2022, COVID-19 control required all male new admissions to be cohorted in a single building, which in turn requires the availability of wide range of clinical services during the critical per-admission [sic] period, in a facility that was slated to be closed prior to COVID-19.
>
> The strains of care delivery through the pandemic, as well as DOC's recent staffing crisis, have led to significant challenges in care delivery that vary from week to week. In the face of this, CHS has continued to meet its obligations throughout this period, but clinical prioritization has been necessary as the overlapping downstream effects of COVID-19 still present a fluid situation. CHS has experienced significant attrition and COVID-19 has also hindered CHS long-term recruitment efforts, such as clinical rotations and in person recruiting, all while destabilizing the healthcare labor market.
>
> Elmhurst's forensic unit D11 closed on April 7, 2020 due to the COVID-19 pandemic and the resulting surge plan needs at the facility. The D11 patients were transferred to Kirby Forensic Psychiatric Center.[7] Subsequently, D11 underwent renovations. On December 28, 2020, due to an increased demand for forensic beds, 6 forensic beds were opened temporarily on unit A5 at Elmhurst. However, due to a staffing shortage at DOC, A5 temporarily ceased operations on December 7, 2021. At the time of closure, three patients were admitted to A5, two were transferred to Kirby and one returned to Rikers Island. A5 remains closed. Elmhurst plans to reopen D11 in mid-May 2022, subject to DOC ability to staff" (Defendants' response to request for information, Report 49).

Information provided by CHS, supported by information we obtained via chart reviews and staff interviews, indicates an ongoing state of crisis impacting the basic delivery of

[7] Defendants informed us that a total of 14 class members were sent to Kirby after April 7, 2020, due to the unavailability of EHPW for acute mental health care (Defendants' response to follow up requests, May 5, 2022).

services. This reporting period saw continued problems with production of class members for mental health and social work services and increased vacancies in all job categories providing or supervising social work services except for those providing clerical support.

During this reporting period, production by DOC of class members for mental health and discharge planning appointments decreased: patients were produced for 53.8% of mental health appointments and 70.4% of reentry appointments. Social Work and Mental Health staff cannot provide required services to a class member who is not made available for an appointment (See Sections IV.C and IV.D for more information regarding this problem and its impact on mental health and discharge planning services).

The overall state of disorder on Rikers Island predictably leads to fear among staff and class members alike, low staff morale, worsening problems with recruitment and retention, and difficulties in performing basic correctional functions such as ensuring a reasonably secure and safe environment or access to needed care and treatment. It is predictable that discharge planning will suffer in the midst of such turmoil. Until defendants stabilize and resolve the crisis – the root causes of which are beyond the scope of this report – they will continue to have great difficulty complying with the various obligations they incur under the Stipulation.[8]

Population and Census Trends

Our recent reports have discussed the changing population in the DOC, noting the relative increase in class membership with respect to the overall population. There are

[8] In 23 cases, a DCP was not completed for reasons related to the chaotic conditions in the jails, mostly related to nonproduction of class members for required services. As discussed in detail in sections IV.C and IV.D below, the current cohort includes many more such cases than in recent prior reporting periods. While they draw different conclusions, both defendants and class counsel in their comments to the draft of this report underscore the degree to which the current conditions interfere with CHS's ability to provide basic mental health and discharge planning services.

various reasons for this population shift, including changing criminal justice approaches, most of which are beyond the scope of this report.

Overall Population Trends: Defendants provided data for the Average Daily Population ("ADP") of the system from July 2019 through March 2020, allowing an understanding of the changing size of the DOC population as bail reform came into play effective January 1, 2020, and through the acute and early recovery phases of the COVID-19 emergency. Since April 2020, we have been gathering data weekly from the NYC Open Data website regarding the DOC population.[9] Figure 1 demonstrates that, beginning in April 2020, class members accounted for the majority of the population of the New York City jail system. Over the past year, class members have accounted for between 47.4% and 52.9% of the DOC population, which appears to have stabilized at approximately 5600.

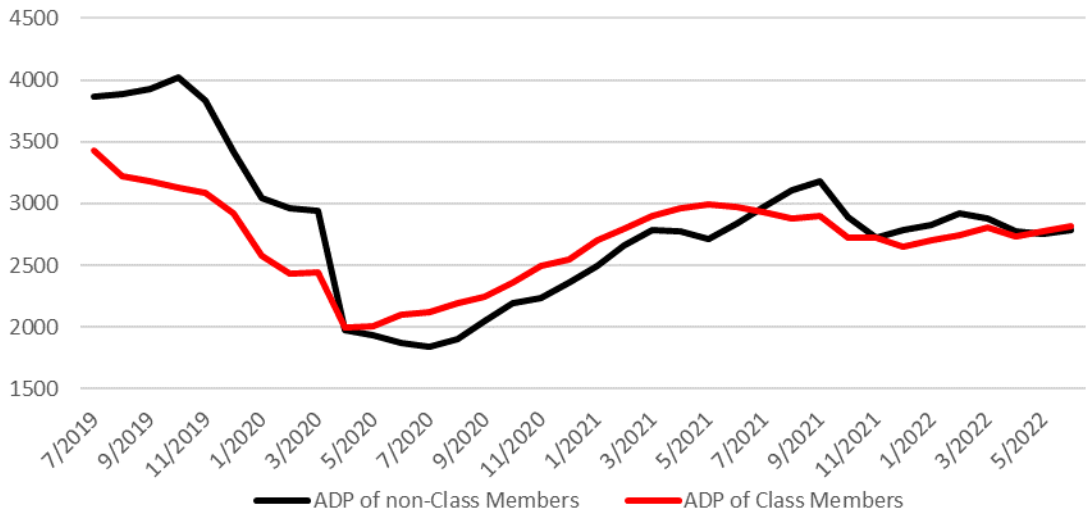


Figure 1: Class Member ADP and non-Class Member ADP, July 2019-June 2022.

These data do not account for detainees early in their incarceration who will become class members; during the very earliest part of their detention, detainees have not yet been assessed for mental illness and are included in the dataset as non-class members. Historically,

[9] See https://data.cityofnewyork.us/Public-Safety/Daily-Inmates-In-Custody/7479-ugqb.

about half of those who remain incarcerated subsequently will be assessed as meeting the class member definition after undergoing sequential mental health assessments and treatment plans. Detailed analysis of the inmate population data from April 25, 2022 indicates that it was only by day 45 that the class member prevalence approached 50%.[10] Nearly two-thirds of those who stayed more than a year, and 70% of those who stayed more than two years, were class members. This may be partially explained by the built in temporal delays in designating detainees as class members, but also by the well-known phenomenon that inmates and detainees with mental illness remain incarcerated for longer periods of time when compared to those without mental illness. The upward trend is clearly demonstrated in the following figure:

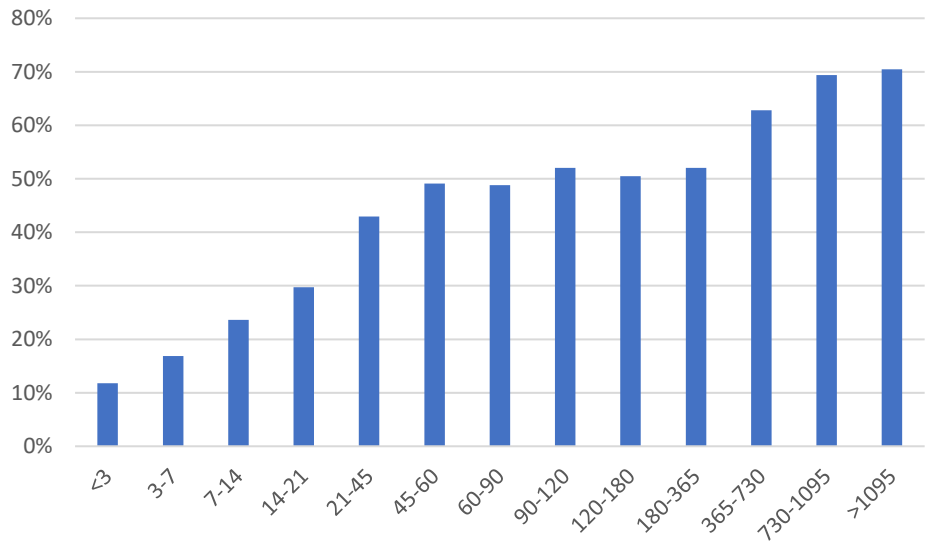


Figure 2: % of class membership, by LOS (days), April 25, 2022

Class Members with SMI: During the time in which bail reform went into effect, the population of class members with SMI declined at a much lower rate than the overall class or

[10] As class counsel point out in their comment regarding case 95, delays in initial assessment can result in inmates and detainees with mental illnesses not being determined to be class members because they are not timely seen, assessed and diagnosed. In that case, the class member was referred STAT to mental health on August 30, 2021 but was not seen by MH until October 14, 2021, 45 days later. Had he been discharged during this unexplained 45-day delay, he would not have been considered a class member.

than the jail population as a whole (See Report 44, Table 2, p. 27). Since that time, defendants provided updated information regarding the SMI population during the COVID-19 crisis.

Table 2: Size of various populations pre- and post-COVID-19, with relative changes at various times, compared against a pre-COVID-19 baseline in February 2020. The numbers here reflect monthly ADPs for the given months and may differ from weekly data used to create the figures above.

	# of non-CMs	# of non-SMI CMs	# of SMI CMs	TOTAL Class	TOTAL
Feb-20	2965	1632	806	2438	5403
Jul-20	1845	1574	553	2127	3972
	(37.77%)	(3.55%)	(31.39%)	(12.76%)	(26.5%)
Nov-20	2223	1731	750	2481	4704
	(25.03%)	6.07%	(6.95%)	1.76%	(12.9%)
Mar-21	2790	2004	897	2901	5691
	(5.90%)	22.79%	11.29%	18.99%	5.33%
Sep-21	3182	1937	959	2896	6078
	7.32%	18.69%	18.98%	18.79%	12.49%
Mar-22	2877	1917	892	2809	5686
	(2.97%)	17.46%	10.67%	15.22%	5.24%

Table 2 compares the size of the non-class-member population with the SMI and the non-SMI class member populations from prior to the COVID-19 pandemic until September 2021.

- In the first few months of the COVID-19 pandemic, both the non-class member and the SMI populations decreased by approximately one-third, while the non-SMI class member population barely fell at all.
- Over the next few months, all three populations increased, and non-SMI class members exceeded the baseline from the previous February.
- As of March 2021, the class membership increased by nearly 20% when compared with February 2020. Both populations of class members now exceeded the baseline by a significant amount, and the non-class member population increased but was still about 6% lower than baseline.
- In September 2021, the non-class member population exceeded the population in February 2020 by over 7%, and the class member population, and the SMI subset, both exceed the February 2020 populations by nearly 19%.
- By March 2022, the non-class member population had dropped by nearly 10% over the previous six months and was about 3% lower than the February 2020 baseline. In contrast, while the class member population and the SMI subset were slightly lower than they had been six months previously, they continued to exceed the baseline by 17% and 11%, respectively. This is demonstrated in the following graph, which includes the February 2020 baseline population numbers and the population as of March 2022:

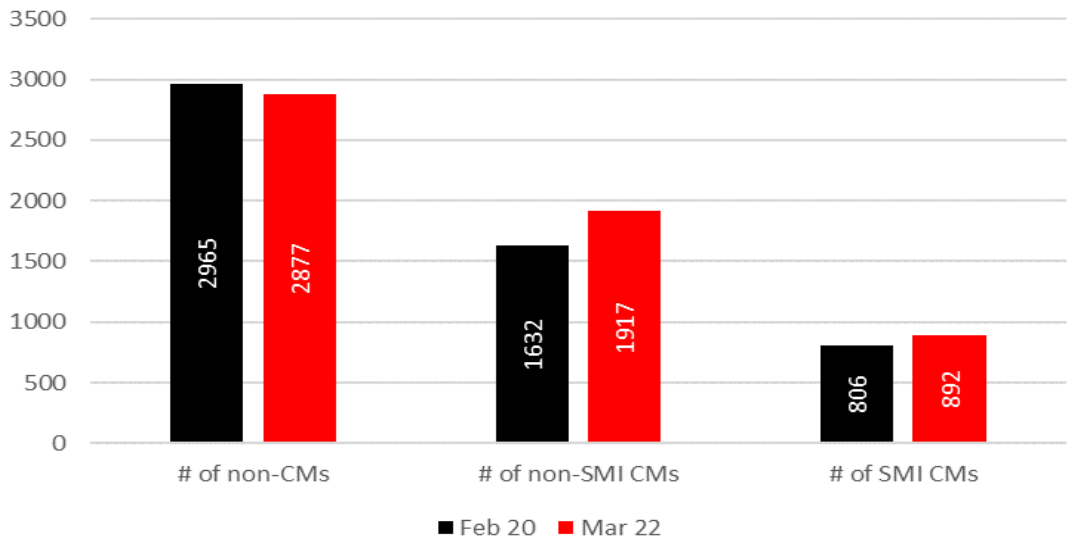


Figure 3: Population changes from February 2020-September 2021-March 2022

As of March 2022, the DOC population is over 5% larger than it was just prior to the onset of the COVID-19 pandemic, driven by a 15% increase in the class member population when compared with February 2020.

Examining the SMI population specifically, it is notable that the percentage of the DOC population which is SMI has increased since the early days of the COVID-19 pandemic. Initially, the percentage of the population that is SMI dropped, but since November 2020, the prevalence of SMI class members has exceeded its prevalence from prior to the onset of the pandemic. SMI class members consistently make up nearly 16% of the total population.

Table 3: Changing prevalence of SMI among the DOC population

	% of population that is SMI
Feb 20	14.92%
Jul 20	13.92%
Nov 20	15.94%
Mar 21	15.76%
Sep 21	15.78%
Mar 22	15.69%

The data presented above demonstrate that while the jail population initially decreased significantly during bail reform and the early months of the COVID-19 crisis, the class

member population initially decreased more slowly, and the class member population remains substantially larger than it was pre-pandemic. Since mid-July 2021, class members made up nearly half of the total population, and the SMI population continues to exceed its pre-pandemic level. This underscores the importance of not losing focus on DCP in the midst of the current crisis.

II. Policies and Procedures

Subject: Defendants will have discharge planning-related policies consistent with the requirements of the amended Stipulation and the additional measures required by the Court's April 18, 2014, September 19, 2014, and April 26, 2021 orders.

A. CHS Social Work Policies

Key References: ¶¶20, 127, 129 and 149(d); Social Work and Re-Entry Procedures Manual; CRAN Manual; MH Policies 5, 10, and 11; Report 48, pp 22-25.

Discussion: In our information request for the 47th report, we inquired of defendants "how early… HRA [would] accept a [2010e] reapplication prior to the expiration date so that the individual's approval does not lapse?" In their response, HRA stated that "Supportive housing applicants can apply within sixty (60) days of the expiration date." The most recent version of DCP Policy 3.7 requires staff to resubmit 2010e applications for "class members ***incarcerated longer than one (1) year***" (emphasis added). Tying the reapplication date to the length of stay—as the current manual does—is flawed in that

- HRA approvals are rarely obtained within the earliest days of an incarceration,
- some class members may initially refuse or not be eligible for a supportive housing application but may later agree to submit one, and
- some people are incarcerated with already approved applications that will lapse within a short period after remand.

We recommended that the policy require reapplications to be offered to class members ***approximately 60 days prior to the expiration date of the prior approval***,

whether that approval was obtained during or prior to the instant incarceration. In their comments to the draft report, defendants indicate that they believe our suggested language to be "unnecessary," because "Social Work already regularly reviews, reoffers, and resubmits supportive housing applications for class members." See, however, case 117,[11] which demonstrates that defendants' position regarding this policy is ill-founded.

B. **HRA Policies**

On April 27, 2020, we received a revised version of the Brad H. Policy Directive Project #4575, which replaced Policy Directive #06-03-ELI. We provided comments concerning this policy to defendants on May 11, 2020.

On December 18, 2020, HRA provided responses to our suggestions, which they accepted in nearly all cases. Additionally, defendants offered to provide redacted approval and denial notices as well as blank manual acceptance/denial notices for our review. At that time, defendants were preparing an updated version of directive 4575 incorporating our feedback.

On April 7, 2021, defendants provided a "final redlined" version of this policy which is "…now being reviewed by New York State" (Defendants' response to request for information, report 47). With the policy, defendants sent a file containing various attachments to the policy, including a document titled "Interview Required to Complete Your Cash Assistance Application." On April 12, 2021, and again on June 14, 2021, we inquired of counsel how this attachment is forwarded to an incarcerated class member who has completed the PA application. On June 18, 2021, defendants responded that this "form is mailed to the class member," but they did not indicate where the form would be

[11] All references to specific cases relate to the cases we reviewed for appropriateness and are described in detail in Exhibit 2.

mailed in order to reach an incarcerated or recently released class member. We requested further clarification on June 21, 2021.

In connection with their response to the request for information for the 48th report, HRA provided a revised version of Policy Directive #4575. This policy indicates that Form FIA-1212a is to be used to notify the person that an interview is required to complete their cash assistance application. HRA noted that per that policy, the notice

> "is sent to the mailing address on record for the Class Member. All HRA applicants and recipients are required to have a mailing address to receive correspondence from HRA. If the individual does not provide a mailing address, HRA will set as the default mailing address the address of the General Post Office in the borough where the individual resides/spends most of their time" (Defendants' response to request for information, report 48).

HRA further noted, that

> "[t]he most recent Draft Policy Directive also provides for Form FIA-XX2282 ("Important Information About Getting Benefits") to be ***handed*** to the Class Member at discharge. This will be given to the Class Member in lieu of the Referral Letter and provides them with clear information on how to contact HRA regarding their application, or with any other questions. The Referral Letter, which previously identified an individual as a Brad H. Class Member when they arrived at a Job Center, is now obsolete. Brad H. Class Members with pended applications are now identified by the Job Center designation 68, which is assigned when the application is pended.
>
> Copies of Draft Policy Directive #4575 and Form FIA-XX2282, which have been submitted to the Office of Temporary and Disability Assistance (OTDA) for approval…" (defendants' response to request for information, report 48, emphasis in original).

This straightforward form provides clear contact information for the class member to get in touch with HRA. We noted that it was unclear whether the obligation to hand this document to class members at the point of release rests with CHS or with DOC.

In their response to the information request for the current report, defendants noted that

> "The New York State Office of Temporary and Disability Assistance ("OTDA") has not yet approved HRA Policy Directive 4575. The last inquiry was sent to OTDA on March 11, 2022 by the HRA Office of Policy, Procedures and Training ("OPPT") and there has been no response to date. OPPT is diligently following up on the matter."

Subsequently, in their comments to the draft report, defendants informed us that:

> "The NYS Office of Temporary and Disability Assistance (OTDA) has informed HRA that they will provide feedback on the Policy Directive shortly, hopefully within the next two weeks. HRA will provide the final version of the Policy Directive once it has been approved by OTDA."

We requested that defendants inform us which agency will be responsible for distributing this "important information about getting benefits."

HRA currently indicates that:

> "FIA-XX2282, attachment to Policy Directive 4575, was finalized on December 6, 2021, and given the new designation FIA-1212a…. FIA-1212a was sent to CHS on December 23, 2021 and HRA was advised it would be distributed to SMI Class Members at discharge" (Defendants' response to request for information, report 49).

It appears that CHS will be the agency responsible for providing this form, which provides important information about securing emergency benefits, to class members upon release. Assuming this is so, CHS will need to develop policy and train staff as to this obligation.

C. **Forensic Unit Policies**

After substantial discussion and document exchange, the forensic units engaged in a teleconference with the monitors to discuss our comments concerning a set of revised draft policies on August 16, 2019. The monitors have had considerable back and forth with the forensic units about these policies, but arriving at final, acceptable policies has remained challenging for H+H.

Defendants previously indicated that "H+H is reviewing its Policies in light of the last round of edits received from the Monitors and expects to submit them to the Monitors in

early September [2020]" (Defendants' Response to Request for Information, Report 45). On September 14, 2020, defendants' counsel forwarded copies of updated policies; we reviewed these policies and provided comments on October 5, 2020. Defendants provided their responses to our recommendations on November 4, 2020. We provided comments to defendants on November 18, 2020.

In an email on February 3, 2021, defendants provided updated versions of these policies, noting that "[a]bsent any substantive issues, H+H now considers these final." On February 9, 2021, we responded that because these were not redlined, we were unable to determine what changes defendants had made to the most recent versions. We requested that they provide either redlined documents or otherwise indicate which recommendations were accepted, and which were not, as well as indicating all changes made from the prior versions. On April 7, 2021, defendants provided versions of these policies that appeared not to include edits made after September 2020, in two sets previously provided in November 2020 and February 2021. After attempting to review them, on April 12, we sent an email to counsel for defendants requesting that they provide the most up to date versions of the policies, making it clearer which of our recommendations had been accepted, and which had not.

On May 26, 2021, Defendants forwarded updated versions of these polices. We reviewed these on May 28, 2021, noting that most of the issues we raised had been addressed but that some had not, and that we continued to have significant concerns regarding Policy 9, Access to Community Discharge Resources. We suggested that further document exchange was unlikely to lead to a resolution and requested counsel's

assistance in arranging for a discussion with forensic unit staff and leadership regarding our remaining concerns.

On July 13, 2021, we conducted a web conference with hospital and forensic unit leadership. The meeting was a constructive and productive exchange of ideas and viewpoints; at the culmination of the meeting, defendants agreed to consider revisions to Policy 9 in light of our discussion.

On October 8, 2021, defendants provided a significantly revised version of this policy, noting that the forensic units again considered it to be a "final version" (Defendants' Response to Request for Information, Report 48). We found this version of Policy 9 to be significantly improved over previous versions, addressing almost all our concerns.[12] The remaining issues we recommended the forensic units address are as follows:

1. The policy on page 4 directs staff to wait until a class member's known release date to forward HRA 2010e approvals to housing providers. Such a delay will guarantee that class members with supportive housing approvals will have no chance of gaining housing prior to release. The Stipulation requires defendants to submit approvals to housing agencies, without regard to whether there is a known release date.

2. Similarly, on pages 4 and 5 the policy requires submission of applications for CRAN or other case management services only following knowledge of a known release date. Class Members should be referred to CRAN and any other case management services for which they may be eligible at the point of their initial DCP.

Defendants informed us on April 21, 2022 that:

> "The forensic units have not rejected the recommendation. In fact, they are completing the housing application for all class members who qualify. The

[12] As class counsel point out in their comments to the draft of this report, once these policies are finalized in a manner that comports with the requirements of the Stipulation, training will be required for staff and supervisors to ensure that they properly implement the modified policies.

forensic units are reviewing the Monitors' feedback" (Defendants' response to request for information, Report 49).

In response to our follow up request, defendants provided the following data and explanation:

Table 4: HRA 2010e applications submitted, July-December 2021

	BHPW	EHPW A5
July	0	0
August	0	2
September	0	0
October	0	1
November	0	0
December	0	1

"[O]f the 197 patients admitted to BHPW in this time period, 74 were transferred to inpatient civilian psychiatric unit or a forensic state facility (Kirby) for ongoing treatment, and were therefore too unstable for the HRA 2020e process. The other 123 patients either refused, were already stably housed, had a 2010e completed by CHS prior to admission to BHPW, or were too psychiatrically unstable to engage in the process."

In their comments to the draft report, class counsel commented that

"The failure to submit any supporting housing applications [at BHPW] suggests that Defendants continue to construe eligibility narrowly. Defendants' assertion that all Class Members transferred to an inpatient civilian psychiatric unit were too unstable for the HRA 2020e process is questionable. The need for hospitalization alone does not establish that a supportive housing application cannot be initiated. In fact, in Case 33 the Class Member was transferred to a civil unit because he was at risk of decompensation if released without housing in place. The social worker submitted a SPOA application on this Class Member's behalf and certainly could have completed a supportive housing application if needed. It is likely that among the 74 Class Members transferred to other inpatient treatment units, there were Class Members stable enough to have the supportive housing process initiated."

Next Steps

1. In light of case 117, discussed above, CHS should reconsider their rejection of our recommendation to revise policy 3.7 to accommodate the changes in HRA practice and to accommodate the variations on when a 2010e should be resubmitted, as outlined above.

2. HRA should provide the final policy 4575 after the State's review. Defendants have apparently determined that CHS will be responsible for providing form FIA-1212a to class members; CHS needs to create appropriate policy or directive language and training for staff to ensure that class members are properly informed of the need to present themselves to a Job Center after release.

3. The forensic units should provide updated drafts of the forensic unit policies; we urge them to reconsider our recommendations regarding Policy 9.

III. Staffing and Training

A. Staffing Levels

Subject: On April 18, 2014, the Court ordered defendants to "make the necessary administrative changes to fully staff all clinical and non-clinical discharge positions." In its September 19, 2014 order, the Court noted that "an almost 10% rate of unfilled positions" is inadequate. On April 26, 2021, the Court ordered defendants to "…fully staff all discharge planning positions." Since 2014, defendants have increased their social work staffing allocation but at no time have they approached fully filling either the original or augmented allocations. Defendants have not engaged in any discussion as to their staffing methodology or how they arrive at specific allocations. We take their allocations at face value as defendants' expression of the staffing required to meet the needs of the class.

Key references: ¶¶5, 9, 108, 118, 120, 148, 149(c) and (d); Court orders of April 18, 2014, September 19, 2014, and April 26, 2021; Report 48, p 30-31.

Compliance: The current allocations and fill rates are as follows:

Table 5: Staffing of SW positions as of April 21, 2022

	# of allocated positions	# of positions filled		# who left since 10/8/21	# hired since 10/8/21	# currently in the hiring process	# of vacant positions	Permanent staffing rate
		Permanent	Temporary					
SW Supv.	14	11	0	2	0	0	3	78%
SW	39	21	2	3	2	3	18	54%
Caseworkers	18	13	0	3	1	2	5	72%
Clerical	8	7	0	1	1	1	1	87.5%

This shows an increase in vacancies in all areas except for clerical, with a net loss of three supervisors and a net loss of five additional social workers; almost half of the allocated social work positions are vacant.

CHS reports that

> "CHS has experienced significant attrition and COVID-19 has also hindered CHS long-term recruitment efforts, such as clinical rotations and in person recruiting, all while destabilizing the healthcare labor market.
>
> * * * *
>
> "[S]taff outages" due to leave usage have not had a significant impact on operations, as CHS continues to flexibly cover intermittent leaves and minimize the impact to patients. As CHS has noted previously, the primary staffing-related challenge is attrition, which has always been an issue given the challenging jail environment. Anecdotally, staff who have resigned recently cite a number of factors, ranging from general safety concerns about the jail environment to COVID-19 more generally. These recent losses reflect the compounded chilling effect the pandemic has had on CHS' longstanding recruitment efforts.
>
> "However, CHS is proud to share that it recently implemented a major recruitment and retention initiative that it hopes will make CHS a more competitive and attractive employer to new candidates and current staff alike. In recognition of the current, highly competitive health care labor market, CHS has increased salaries for all social workers across the board in addition to promoting all clinical social workers who have their LCSW from Level 2 to Level 3, an important step in the H+H social work career ladder. CHS will continue to monitor the impact of this key initiative on recruitment and retention" (Defendants' response to request for information, Report 49).

B. **Training Update**

Subject: Staff require ongoing training to help guide them in the proper performance of their clinical and discharge planning responsibilities.

Key References: ¶¶127, 131; Report 48, p 31.

Discussion:

CHS Trainings: CHS conducted or facilitated the following trainings for social work and CRAN staff since October 8, 2021:

3/28/2022	CONNECT clinics (see Section IV.D below)	Monitors attended
4/12/2022	SPOA referral process	Monitors attended
4/28/2022	AOT referral process	One monitor attended
5/5/2022	Housing referrals part 1	One monitor attended
5/10/2022	Housing referrals part 2	Monitors attended
5/18/2022	Veteran's benefits	One monitor attended

Additionally, "CHS continues to develop a new PTSD training to address the importance of conducting and documenting a full functional assessment…." (Defendants' comments to draft Report 49).

Forensic Unit Trainings: On June 15, 2022, the forensic units informed us of a two-part training on "The Everyday Practice of Providing Mental Health Treatment to People in the New York City Criminal Legal System," which the BHPW SW staff would be attending on June 15 and June 22, 2022. Because of the late notice, we were unable to attend this relevant training.

CRAN Trainings: During this reporting period CRAN continued to conduct and keep us informed of regular training on relevant topics.

No other defendant agency conducted any training relevant to the Stipulation. *DOC* staff continue to require training in connection with the agency's obligations under the Stipulation, specifically regarding parole violators, as discussed in Section IV.I below.

IV. **Performance**

A. **Electronic Medical Record**

Subject: Clinical and discharge planning information regarding class members is only available electronically. The monitors did not have access to the EMR system

(eClinicalWorks, or eCW) which CHS utilized for years. When charts were required for review, a cumbersome, inefficient, and time-consuming process had to be undertaken.

In August 2019, Defendants transitioned to a new EMR platform (CHER).

Key References: ¶¶120, 121, 122, 123 and 148; Report 24, pp 35-37; Report 48, pp 32-34; Decision and Order on Motion, April 26, 2021.

Monitoring Issues: Previous reports have outlined in detail the interference with our monitoring activities resulting from defendants not providing direct access to class members' electronic medical records, compounded by the obligation defendants took on as they attempted to produce complete PDFs of those records in accordance with agreed-upon timeframes. Upon learning in December 2018 that defendants were moving to a new EMR system, we observed that this transition provided a new opportunity to remedy this problem. Until such a remedy was in place, we repeatedly concluded that it was unfortunate that defendants were unable to come into compliance with their obligations under ¶¶120 and 122.

CHS transitioned to its new EMR (CHER) in July 2019. They subsequently developed an interface (CHARM) to provide us access to some portions of the record which we started using on February 5, 2021. While we appreciated CHS's efforts, we determined that CHARM:

1. did not represent direct access to the EMR as we had expected, instead merely providing a new way to provide extracts of certain portions of the CHS record;
2. did not solve the problem of real time access to class members' records during site visits;
3. did not solve other concerns, such as our inability to conduct record review of groups of class members having certain characteristics or receiving certain services (Stipulation ¶122); and
4. introduced various inefficiencies into our chart reviews without providing the expected benefits.

Following several communications with CHS concerning possible modifications to the interface aimed at reducing the inefficiencies introduced, in an email of April 8, 2021, CHS indicated that they found some of our requests for modifications to CHARM feasible while others were not. Unfortunately, the requests CHS determined not to be feasible were among the most essential for our purposes. CHS also indicated their willingness to accommodate our request that, pending a potential resolution of our concerns, they return to providing records in PDF format.

On April 26, 2021, the Court ordered defendants to provide the monitors with access to class members' electronic medical records (Decision and Order on Motion April 26, 2021).

No communication concerning this issue ensued until defendants responded to our request for an update on their efforts to comply with this order as part of their October 8, 2021 response to our request for information for the 48th Report. Their response recounted this history in detail noting their concern that "direct access to CHER could not be provided due to an inability to separate Class Members from non-Class Members and… an inability to redact HIV and substance use disorder records within the EMR for patients who have not given consent." They further noted that some of the requested modifications to CHARM we considered most essential were "also not possible in CHER, and therefore direct access to [their] electronic medical record will not resolve the Monitors' requests related to CHARM."

Defendants then added that:

> "On April 26, 2021, the Court ordered the City to provide the Monitors with access to Class Members' electronic medical records. Despite longstanding legal concerns that providing direct access may violate various state and federal privacy law, CHS has asked H+H's Office of Legal Affairs (OLA)

> to review and opine on the legality of doing so and will return to this topic with the Monitors when OLA issues their opinion."

In their comments to the draft report, defendants informed us that

> H+H's Office of Legal Affairs (OLA) has reviewed and confirmed infeasible providing the Monitors direct access to CHS' electronic medical record system. Electronic access to class member records as currently provided is the only way in the system to still protect the records of non-class members. We remain open to suggestions from the Monitors about improvements to the current method of providing patient records, so long as doing so is consistent with applicable confidentiality laws.

B. Data, Data Dictionary, Coding and Crosswalk, and Data Quality Assurance

Data that accurately measure defendants' obligations as outlined in the performance indicators promulgated by the monitors is a primary means by which to determine and report on defendants' compliance with the Stipulation. This requires a data dictionary: a plain language description of how the indicator is to be calculated.[13] With a shared understanding of the data elements which go into the measure and of how compliance is calculated, computer code must be written that accurately translates the performance measures so that compliance statistics can be produced. Part of the evaluation of the adequacy of this process is the development of a crosswalk showing where various data elements are found in both the primary source and in the code used to perform the calculations.[14]

Once these are created, they should lead to an adequate data production system. After an adequate system is established, it must be sustainable over time. Sustainability requires an ongoing data quality assurance system to discover and remedy any problems

[13] In addition to a statement of the indicator, the data dictionary should include a listing of the logical elements used to calculate the indicator for each class member as well as the logic employed in the calculation.
[14] The crosswalk should contain all logical elements listed in the data dictionary, their corresponding derivations in the source documentation and in the electronic medical record, and an indication of where and how the logic for each indicator is implemented in the source code.

with data, something defendants were ordered to develop [Court orders of April 15, 2014 and April 26, 2021].

As explained in detail in Reports 45-48, defendants had not provided compliance data since August 2019. On October 8, 2021, defendants indicated that "CHS intends to produce missing or incomplete PI data from July 2020 through July 2021 before the end of October, 2021…. CHS will provide the coding and crosswalks at that time" (Response to request for information, Report 48). On November 8, 2021, defendants provided data covering July 2020-August 2021.

On December 30, 2021, defendants provided an updated data dictionary at which time they indicated that "CHS is currently in the process of finalizing the coding and crosswalk used to produce the Performance Indicators, and we should have it for your review shortly" (email from CHS). We requested a redlined version to ascertain what revisions had been made to a document that had previously been agreed to by all parties. Defendants provided the redlined version on January 28, 2022, and plaintiffs submitted their comments on this document on March 4, 2022. The monitors provided defendants with detailed comments and suggested revisions on March 11, 2022.

In their comments to the draft report, provided on June 3, 2022, defendants indicated that

> CHS will submit the revised data dictionary in the next couple of weeks. The detailed programming code and crosswalk document (from Data Dictionary to Programming Code) will be provided to the monitors once the data dictionary is finalized and approved. CHS will then be available to meet with the Monitors and their data expert to answer any outstanding questions.

On June 24, 2022, CHS provided an updated, redlined version of the data dictionary. We will review this as soon as possible during the coming reporting period. After the data

dictionary is finalized, CHS will need to provide the underlying coding and the crosswalk that will allow us to make definitive compliance findings.

C. **Performance Indicator Data**

Subject: The Monitors are required to establish performance goals, set expectations, and monitor defendants' performance against those expectations. The Stipulation sets out a series of performance goals related to assessment, treatment planning, and discharge planning. The Stipulation also permits the monitors to establish other performance goals as necessary to effectuate the terms of the Stipulation. The current PIs are included in Appendix 4 of the Thirty-Eighth Report.

Key References: ¶¶49, 100, 140-147.

Monitoring Issues: In prior reports, we noted various limitations precluding detailed and granular analyses of defendants' performance, such as the inability to provide site-specific performance data. Additionally, we have repeatedly noted discrepancies between defendants' reports and data gleaned from chart reviews.

Defendants were long delayed in providing compliance data for numerous performance measures, as required by ¶124. In late 2019 and early 2020, these delays were associated with their change in electronic medical records (see Report 44, Section V.A), with the attendant need to modify their data extraction and reporting processes. During the acute phase of the pandemic, we supported CHS' decision to prioritize patient care over the production of retrospective data (see Report 45, Section V.C). As discussed in more recent reports, the status of the pandemic in New York City in general and in its jails in particular has improved significantly. CHS began providing data in November 2021, and they have now reestablished their monthly data provision schedule. However,

as noted above in Section IV.B., without a revised agreed upon data dictionary, along with the underlying coding and crosswalks, we are unable to assess the validity of the data.

Therefore, we continue to find defendants out of compliance with ¶124. Notwithstanding defendants' objection unless ordered otherwise by the Court, we will continue to follow the approach outlined in our Forty-Fourth Report (pp 54-56) and its supplement.[15] Where no data, or where only unverified data[16] is provided and no data from chart review is available, we will indicate that defendants continue to be unable to demonstrate definitive compliance; this is the case for measures 1.1, 4.1.2, 5.1, 5.2.1, 5.3.1, 5.3.2, 7.1.1, 7.1.2, 7.1.3, 8.1, 8.2, 8.3, 9.2, 10.1, 10.2, 11.1, 11.2, 12.0.1, 12.0.12, 12.0.2, 12.0.3, 12.1, 12.2, 12.3 and 12.4. Where information concerning a specific PI is available based on chart review (PIs 3.1, 3.3 and 4.1), we will make tentative findings subject to revision if and when global verifiable data is provided. Where data is available from HRA (PIs 6.1, 6.2, 9.1 and 9.3), we report the data and make findings as to defendants' compliance.

[15] "Defendants repeat their objection to this form of monitoring and any conclusions that might be drawn from an 'appropriateness' sample of a limited number of cases when for other indicators the entire universe is used to calculate compliance percentages" (Defendants' comments to draft report 49).
[16] See Section IV.B above.

Barrier to Compliance with the PIs: Non-Production of Class Members for Mental Health and Discharge Planning Services

Production rates during the current reporting period were as follows:[17]

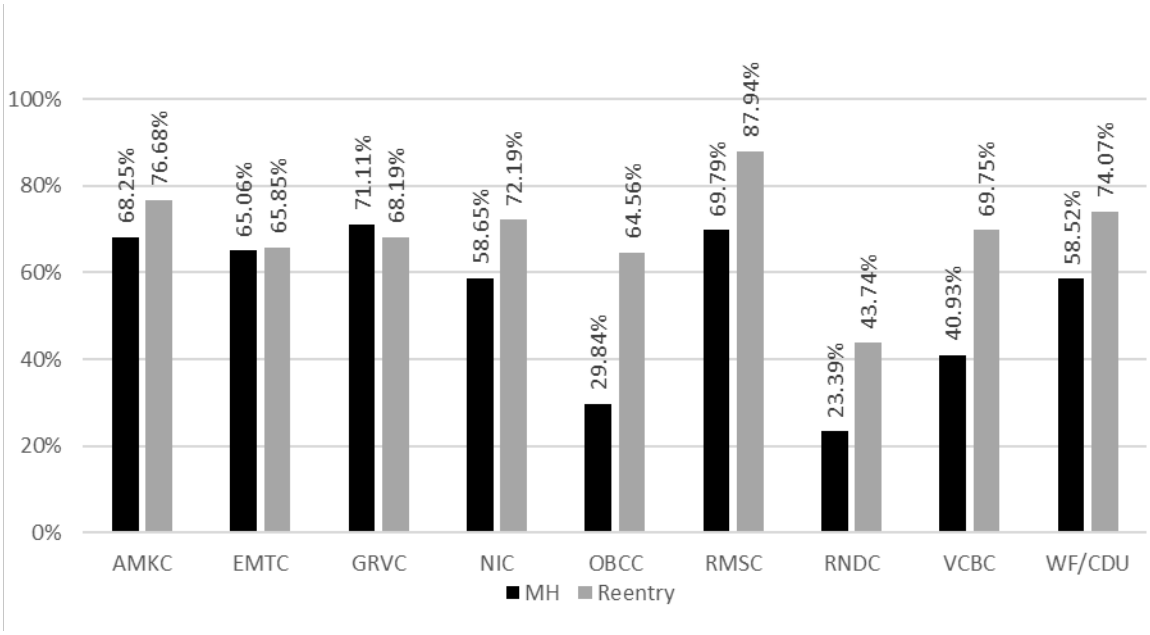


Figure 4: Production rates for mental health and reentry services, by jail, July-December 2021

- For mental health services, the overall production rate was 53.8%, down from 65.5% in the last report
  - Production rates varied from 23.4 % at RNDC to 71.1% at GRVC.

- For reentry services, the overall production rate was 70.4%, down from 73.1% in the last report
  - Production rates varied from 43.7% at RNDC to 87.9% at RMSC.

Comparing this graph to Figure 4 in our Forty-Eighth report, it is evident that production was almost uniformly down in nearly all jails.

Table 6: Production rate differences in 49th reporting period compared with the 48h reporting period.

	AMKC	EMTC	GRVC	NIC	OBCC	RMSC	RNDC	VCBC	WF/CDU
MH	-2.51%	-3.17%	-6.26%	-22.88%	-19.58%	-21.02%	-15.14%	-12.29%	-12.25%
Reentry	5.00%	-6.69%	-1.70%	-10.75%	-11.48%	1.75%	-21.38%	-3.85%	-1.77%

[17] CHS production reports are available at https://www1.nyc.gov/site/boc/reports/correctional-health-authority-reports.page. These reports, while somewhat informative, have two primary deficits from the perspective of monitoring the Brad H Stipulation:

1. The reports categorize all reentry services (whether Brad H related or not) into a single report; and
2. The reports do not capture all relevant categories of nonproduction for mental health or social work services.

During the past four reporting periods, production rates for mental health services continued to decrease, while those for reentry services decreased more slowly:

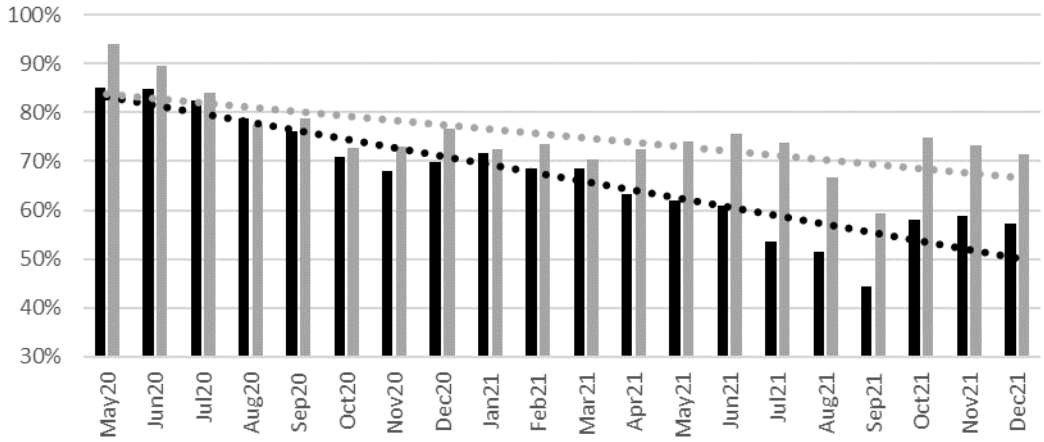


Figure 5: Monthly production rates, May 2020-December 2021.

Given that most clinical and discharge planning services cannot take place if the patient is not present for a service, these low and falling production rates continue to demand urgent attention by defendants. By the end of the reporting period, nearly half of all scheduled MH services and three of ten reentry services did not occur when scheduled because the class member was not produced to the clinic. Nonproduction presents a significant impediment to defendants' meeting their performance goals under the Stipulation. This was again evident in the current cohort.[18] Defendants simply cannot provide a mental health or social work service if the class member is not produced. CHS and DOC should collaborate to determine the reasons for these decreased production rates and rapidly intervene to remedy this unacceptable situation.

[18] See, e.g., cases 4, 57, 61, 63, 64, 65, 85, 86, 105, 145, 147. See case 22, where SW was able to meet with the class member to provide appropriate DCP services on the day of release, after being unable to do so earlier in the incarceration. See also case 146 where there was a "near miss" only avoided by the assiduous work of the MH and SW staff to overcome the difficult position DOC placed them in by recurrent non-productions of a seriously impaired class member.

Discussions of Specific Performance Measures

3.1 Timely Completion of CTP (Mental Health)

Subject: When the initial assessment indicates the need for continued mental health treatment, mental health staff are required to complete a CTP in accordance with a specified timeframe based on the housing level at the time of the initial assessment.

Key References: ¶¶5, 16, 17, 142(d); Mental Health Policy MH 5; Report 48, p 43.

Threshold/Expectation: 95%

Compliance: The appropriateness cohort includes data that allows for an approximation of performance during the current reporting period, indicating that 67 of 124 (54%) cases had the CTP completed according to the relevant timeframes, as follows:

- Compliance in MO (7-day requirement): 44 of 72 (61%)
- Compliance in GP (15-day requirement): 23 of 53 (43%)[19]

In 44 cases, the CTP was between 1 and 32 days late.[20] In 12 cases, a CTP was not done.[21] In case 98, the class member was referred STAT to MH on 9/12/21, but there is no initial assessment in the record; his CTP was completed on 10/20/21, 38 days after the STAT referral. We concluded that this was a late CTP.

Defendants' compliance dropped substantially during this reporting period when compared with the 48th reporting period, when they were compliant in 93 of 120 (78%) of cases. This represents a continued decrease in their performance over the last three reporting periods. Defendants remain tentatively out of compliance.

[19] Defendants' unvalidated data suggest better performance: PI 3.1: 61.37%, PI 3.1.1 (MO) 91.18%, PI 3.1.2 (GP) 53.47%.
[20] Cases 4, 13, 14, 15, 16, 17, 24, 26, 27, 40, 42, 47, 51, 63, 66, 68, 69, 70, 72, 74, 79, 86, 87, 89, 90, 92, 96, 99, 102, 103, 107, 110, 113, 114, 116, 121, 124, 126, 131, 133, 140, 141, 142 and 144.
[21] Cases 54, 57, 61, 64, 65, 75, 76, 85, 118, 122, 145 and 147.

3.3 Timely Completion of Discharge Plan (DCP)

Subject: Upon completion of a CTP, defendants are afforded seven business days to complete the Discharge Plan (DCP). The DCP documents the first interaction with class members where the specific focus is on post-release needs and develops the initial plan to address those needs. It initiates a set of timelines and processes to arrange for community-based care, benefits and supports that will assist class members in their return to their communities.

Key References: ¶18.1, Social Work and Re-Entry Procedures Manual, Section 3.6; Report 48, p 44.

Threshold/Expectation: 95%

Compliance: The appropriateness cohort includes data that allows for an approximation of performance during the current reporting period, indicating that 75 of 124 (60%) cases had the DCP completed within the 7-business-day timeframe. [22] In 26 cases, the DCP was completed between 1 and 85 days late.[23] In 17 cases, no DCP was done.[24] In six cases, the only DCP form in the medical record was completed without the class member's participation.[25] Defendants' compliance dropped when compared to the 48th reporting period, during which they were compliant in 89 of 120 (74%) of cases. Defendants remain tentatively out of compliance.

4.1 Completion of Medicaid Prescreening (jail) (SW)

Subject: The purpose of the Medicaid Prescreening is to allow social work personnel to know the status of each class member's Medicaid shortly after admission, and to allow

[22] Defendants' unvalidated data suggest better performance for PI 3.3: 76.77%.
[23] Cases 1, 7, 12, 13, 15, 21, 22, 25, 26, 33, 36, 47, 52, 67, 69, 72, 88, 89, 102, 103, 106, 121, 122, 141, 142 and 150.
[24] Cases 54, 57, 61, 63, 64, 65, 70, 74, 75, 76, 85, 87, 118, 122, 136, 145 and 147.
[25] Cases 4, 40, 53, 86, 105 and 133.

those personnel to take proper steps to ensure that Medicaid coverage will be available on release for those who are eligible. The prescreening process identifies those class members with active Medicaid at the time of incarceration, those who need a new application submitted, and those whose Medicaid is in "suspension" status as of the time of the prescreening.

Key references: ¶¶5, 59 and 142(e); Social Work and Re-Entry Procedures Manual, Section 3.3; Report 48, p 44-45.

Threshold/expectation: 95%

Compliance: The appropriateness cohort includes data that allows for an approximation of performance during the current reporting period, indicating that 68 cases had the prescreen completed on or before the date of the CTP, as required by ¶59. In eight of the cases in which no CTP was completed, the prescreen was completed prior to the CTP due date and was therefore timely. Thus, defendants met the required timeframe in 76 of 124 (61%) of cases. [26]

In 43 cases, the prescreen was completed between 1 and 168 days after the CTP.[27] Another five cases had no prescreen in the record.[28]

In their comments to the draft of this report, defendants pointed to "OHIS Medicaid Information Templates" in the medical records that indicated a timely prescreen in a few of these cases. We again reviewed these cases and do not find any such templates in the records provided to us. We do find, instead, documents titled "MH – Social Work – Medicaid Application" templates in which SW completes a prescreen that identifies the

[26] Defendants' unvalidated data suggest compliance with PI 4.1, with a 97.53% compliance rate.
[27] Cases 1, 2, 4, 6, 7, 9, 12, 25, 28, 31, 35, 41, 42, 44, 52, 53, 54, 55, 56, 59, 72, 77, 88, 93, 94, 96, 98, 99, 107, 112, 113, 116, 117, 119, 121, 128, 130, 134, 142, 144, 147, 149 and 150.
[28] Cases 63, 104, 108, 122 and 145.

class member's current Medicaid status. Going forward, we will consider the OHIS templates should they be included in the records provided for our review.

At this time, defendants are tentatively noncompliant for measure 4.1.

6.1 Timely Activation of Medicaid Benefits (HRA)
6.2 Timely Unsuspension of Medicaid Benefits (HRA)

Subject: Paragraphs 64.1 and 60.1 require that defendants "take reasonable steps within their control to ensure" that class members' Medicaid is activated or unsuspended within seven or four business days respectively after release.

Key References: ¶¶60.1 and 64.1; Report 48, pp 46-47.

Compliance Threshold: 95%

Compliance:

Medicaid Activation: Defendants are obligated to activate class members' new Medicaid benefits ("P" cases) within seven business days of release. For the current reporting period, defendants reported that three class members had their Medicaid activated two or three business days after release, meeting the timeframe. Defendants were compliant during the reporting period.

Medicaid Unsuspension: Defendants are obligated to unsuspend class members' Medicaid benefits within four business days of release. Defendants provided the following data regarding the timing of unsuspension:

Table 7: Timing of Unsuspension of Medicaid (IC cases), Report 49

# of Days after release	# of cases	%
0	31	9.7%
1	256	80.0%
2	17	5.3%
3	5	1.6%
4	2	0.6%
>4	9	2.8%
Total	320	

Defendants reported meeting the required timeframe in 97.2% of cases. Three of the noncompliant cases were only slightly delayed, but six of them had their Medicaid unsuspended between 18 and 48 business days (or between 27 and 70 calendar days) after release. One class member had his Medicaid benefit unsuspended 18 (27) days late due to a "staff error," but no reason was provided for the other delays. While defendants were compliant, the six outlier cases raise concerns warranting specific investigation as to the reasons for these delays, which can have a direct impact on class members' ability to access services for as long as two months after release.

In four cases, HRA reported that the Medicaid benefit was unsuspended late due to a "DOC discharge data error." These delays ranged from 20 to 194 calendar days. It is unclear why HRA did not include these as delayed unsuspensions. We request that HRA include these cases as noncompliant going forward, and we recalculate defendant's compliance as 96.0%, as demonstrated here:

Table 8: Timing of Unsuspension of Medicaid (IC cases), Report 49, Corrected

# of Days after release	# of cases	%
0	31	9.6%
1	256	79.0%
2	17	5.2%
3	5	1.5%
4	2	0.6%
>4	13	4.0%
Total	324	

Defendants were compliant during the reporting period.

In their response to the request for information for the current report, defendants advised us that

> HRA hosted a CQI meeting on December 13, 2021, but the participants could not isolate the source of the discharge data errors. The Law Department is coordinating a meeting with HRA and DOC to discuss

further the issue and work towards a solution. The monthly Brad H. MAP report now identifies those cases whose activation was delayed due to a DOC discharge date error.

In their comments to the draft report, defendants noted that

> "HRA can only activate or unsuspend Medicaid benefits when it is aware that a Class Member has been released from incarceration. A Class Member's release date is not within HRA's control, nor does HRA have any control over when it receives that information from DOC. Going forward, DOC discharge date error cases will be included in the data analysis in a way that both accurately reflects when Medicaid benefits were activated and unsuspended, as well as when HRA received the discharge date from DOC."

9.1 Provision of Emergency Benefits (HRA)

Subject: The amended Stipulation requires "HRA staff, upon the Class Member's first visit to a Job Center following his or her release date [to] (a) assess the Class Member's need and eligibility for Emergency benefits, [and] (b) provide whatever Emergency Benefits the Class Member needs and is entitled to…." In cases where emergency benefits are not provided, HRA must "document the reasons for the denial" of such benefits.

Key References: ¶85, HRA PD #06-03-ELI; Report 48, pp 47-49.

Compliance Threshold: 95%

Compliance: Defendants provided reports for July-December 2021. Thirteen requests were granted out of fourteen total requests. One request was denied in November with a reason provided. Defendants provided benefits for 13 of 13 eligible requests, and they were compliant for the months of July-October.

In their comments to the 47th Report, class counsel pointed out several cases in which a class member was provided with one emergency benefit (e.g., SNAP) but not another emergency benefit (e.g., cash assistance). In these cases, the reason that the second benefit was not provided was "NA - CM did not request a no food/non-food immediate

need." The implication class counsel draw is that "the language used suggests that there was no ***affirmative assessment***, required both by the policy [4575] and by paragraph 85 [of the Stipulation]" (Class Counsels' comments, report 47, emphasis added). Paragraph 85 requires, in relevant part, that defendants "assess the Class Member's need and eligibility for Emergency Benefits…." Policy 4575 requires that defendants "ask the applicant about emergency situations that may exist and evaluate for immediate needs and/or expedited SNAP…."

In response, defendants reported as follows: "The [Brad H.] liaison assesses any emergency situations ***indicated on the application or that the class member reports during the interview*** and determines whether an immediate need exists" (email from defendants' counsel, June 18, 2021, emphasis added).

As this information does not address the question raised by class counsel, on June 21, 2021, we requested further clarification as to defendants' practice when a class member appears at a job center:

- Do HRA staff verbally inquire about each area of potential need?
- Or, in the alternative, do they only inquire about those needs that a class member affirmatively asserts, either in his/her application or when he/she appears at a Job Center?

In their response on August 3, 2021, defendants reported as follows: "The [Brad H] liaison will assess any emergency situations indicated on the application or that are discussed during the interview and determine whether an immediate need exists." They reiterated this in their comments to the draft 48th report, providing the NY State OTDA Administrative Directive 02 ADM 02 (March 4, 2002) which requires HRA to "***respond to an applicant's declaration of an emergency situation*** at the time of application" (emphasis added). Class counsel, in their comments to the draft report, noted that they

"agreed to the discontinued use of [the immediate needs checklist] based on Defendants' representation that HRA staff ***ask Class Members about their emergency needs*** when they report to the Job Center" (emphasis added).

We have concluded that the use of Form FIA-1212e (formerly FIA-XX2282, discussed in detail in section II.B above) properly advises class members as to how to apply for ***both Cash Assistance and SNAP***. The next steps are for the policy to be approved and finalized, and a process devised for CHS staff to provide class members with the form upon release. Once this occurs, this should sufficiently address our concerns regarding class members' access to needed public assistance benefits.

9.3 Processing and Pending of PA Applications (HRA)

Subject: The Stipulation requires defendants to "register [each PA/SNAP] application on the same day it receives the application."

Key References: ¶78, HRA PD #06-03-ELI; Report 48, pp 49-50.

Compliance Threshold: 95%

Compliance: Defendants registered 441 of 441 applications on the day of receipt, and they are compliant.[29]

* * * * * *

Summary: Defendants were compliant for PIs 6.1, 6.2, 9.1 and 9.3; and they were tentatively noncompliant for PIs 3.1, 3.3 and 4.1.1. For all other measures, defendants were unable to demonstrate compliance because the data they provided for review has not yet been validated by a review of their systems and processes for producing those data (See Section IV.B. above).

[29] Data for August appears to be incomplete, as it ends on August 19. We requested an explanation or updated data from Defendants' counsel on April 5, 2022, but as of the date of this Report, we have received no response.

D. **Appropriateness Measures**

Subject: Defendants are obligated to render appropriate diagnoses and determinations as to the severity of class members' mental illnesses, and to provide appropriate discharge plans consistent with each class member's clinical and psychosocial needs (See Report 45, pp 78-82 for a detailed explanation of the importance of qualitative reviews of defendants' performance in providing mandated discharge planning services). The April 26, 2021, Decision and Order on Motion reaffirmed the importance of defendants' obligations in this area ("…meeting the appropriateness goals is essential to fulfilling the core purpose of the settlement – ensuring that class members receive individualized, clinically appropriate discharge planning," NYSCEF document 76 at p. 12).

Key References: ¶¶142-143;[30] amended Stipulation Addendum A; Social Work and Re-Entry Procedures Manual; Monitoring Plan; Court Orders of September 19, 2014, and April 26, 2021; Report 48, pp 50-61.

Compliance: The threshold for compliance is 95% for the SMI assessment and 90% for appointment or referral, case management, and supportive housing. Defendants were noncompliant in each of these areas. The table below presents the numeric results of our reviews concerning the appropriateness of discharge planning.

Table 9: Summary of Appropriateness Findings

		Appointment/ Referral	SMI	Case Management	Supportive Housing
Eligible	Appropriate	61	113	39	20
	Inappropriate	61	10	20	20
Ineligible or Not Rated		2	1	65	84
Total cases		124	124	124	124
Defendants' compliance		**50%**	**92%**	**66%**	**50%**
Compliance threshold		90%	95%	90%	90%

[30] In addition to these sections defining the monitors' obligation to assess the appropriateness of various actions taken by Defendants, the concept of appropriate services is scattered throughout Section II.H of the Stipulation.

Defendants' compliance over the past nine reporting periods is presented in the following graphs:

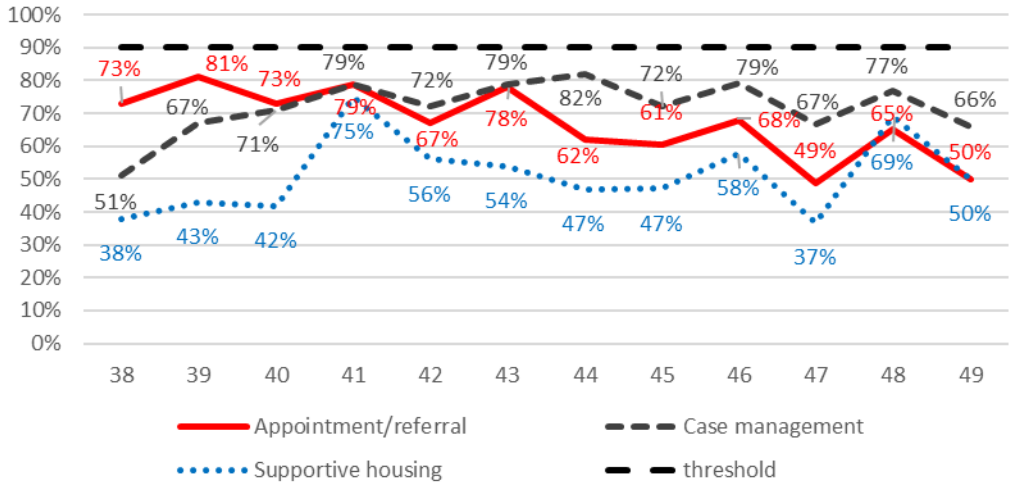


Figure 6: Compliance with Appropriateness Measures, Reports 38-49

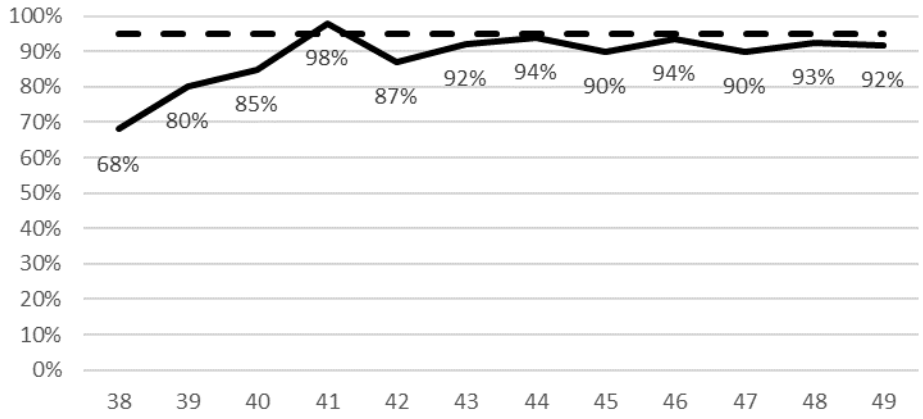


Figure 7: Compliance with Appropriateness of SMI Determinations, Reports 38-49

Defendants' performance decreased for all measures.

Internal Barriers to Compliance: The case reviews in Exhibit 2 reveal a number of areas that defendants will have to address in order to come into compliance.

1. *Diagnostic and functional assessment*: The SMI definition adopted by the Parties in the Amended Stipulation generates four categories of diagnoses which are handled differently regarding the SMI determination:

- Category 1: Diagnosis automatically qualifies as SMI and can only be changed to non-SMI with the approval of both the clinical supervisor and the director of psychological assessment,

- Category 2: Diagnosis automatically qualifies as SMI and can be changed to non-SMI if the class member does not appear significantly clinically distressed or functionally impaired as a result of a psychiatric illness,

- Category 3: Diagnosis does not automatically qualify as SMI but will be determined to be SMI if the class member appears significantly clinically distressed or functionally impaired as a result of a psychiatric illness, and

- Category 4: Diagnosis does not qualify for an SMI rating in any circumstance.

Categories 2 and 3 require the documentation of a ***functional assessment*** to render proper SMI determinations. Fifty-nine cases in the current cohort (48%) had a final category 2 or category 3 diagnosis.

Several cases in the current reporting cycle demonstrate problems with the consideration of functional impairments in making proper SMI determinations. See, e.g., cases 13, 21, 41, 55, 86 and 141. See also case 1, in which the diagnosis was changed from schizoaffective disorder to borderline personality disorder at a TPR, and his SMI status from yes to no, based solely on the diagnostic change. No functional assessment was conducted to support this change in his SMI status, though he was noted to have been using K2 while incarcerated. Despite the diagnostic change and documentation that he lacked signs or symptoms of a psychotic mood disorder, he remained on antipsychotic and antidepressant medications.

Over the past several reporting periods, it has become evident that defendants frequently make the diagnosis of "***other specified trauma and stressor disorder***." In

the current reporting period, defendants made this primary diagnosis in 34 cases,[31] making it the most common diagnosis, more prevalent than schizophrenia (31 cases) or schizoaffective disorder (17 cases).

We are well aware of the prevalence of traumatic experiences, and of trauma-related diagnoses, among the population of incarcerated people. Our concern is not with the frequency of the diagnosis of other specified trauma and stressor disorder but rather with the use of this diagnosis to the near exclusion of diagnoses of PTSD among the class. PTSD should have been diagnosed or, at least, considered in cases 50 and 145 based on documentation of the full symptom cluster required to make the diagnosis of PTSD, which would have automatically resulted in a SMI-yes determination. Additionally, the diagnosis of PTSD and the SMI-yes determination should have been retained in case 86.

Defendants reported that "CHS continues to develop a new PTSD training to address the importance of conducting and documenting a full functional assessment…." (Defendants' comments to draft Report 49). We support defendants' plan to conduct additional training. This training should address the circumstances under which treatment teams should conduct joint case review to reconcile disparate diagnostic opinions within the treatment team. We strongly recommend that this training include extensive education on the significance of the assessment of functional impairment and clinical distress to the ultimate SMI determination when

[31] Cases 4, 7, 8, 21, 31, 35, 37, 50, 53, 54, 57, 59, 61, 65, 70, 74, 79, 86, 87, 88, 89, 90, 98, 99, 114, 119, 123, 124, 128, 129, 130, 131, 137 and 145. In four cases (35, 70, 119 and 129), the class member was rediagnosed with an automatically qualifying diagnosis between one day and 20 months after the CTP.

making category 2 and 3 diagnoses, including other specified trauma and stressor disorder.

We request that defendants provide us with training materials at least 14 days before any training occurs, as required by ¶127.

2. *Treatment team integration*: Fuller integration of treatment teams is required by Court order. We noted in previous reports that treatment teams would function differently in GP, which is somewhat akin to an ambulatory care setting, than in MO/PACE, which is more closely analogous to inpatient care. We further noted that, beyond what can be gleaned from the documentation in medical records, our efforts to better understand how treatment teams function were thwarted by defendants' position that observation of these teams was beyond the scope of our authority. As discussed in Report 48, section II.A, defendants provided an updated draft of MH 49, which drives the treatment team function. We asked a number of questions about this policy, and defendants' responses indicate that treatment team activity will not necessarily be documented in the medical record. Thus, we are left to interpret the documentation that is entered into the record by individual members of the treatment team.

   In addition to cases in which diagnostic uncertainty is not resolved (as discussed above) some cases in the current reporting period highlighted the ***lack of a reliable process by which MH and SW react to changes in class members' situations over time***, where the changing situation warrants a review and update of the previously completed DCP. Case 119 is an example. In this case, the SMI status changed from "no" to "yes" a few weeks after the CTP and the DCP. SW apparently became aware of the change in his SMI status, and when they saw him a month later, they offered a

PA application but no other services for which SMI class members are eligible. SW did not see him again for 7 months, and when they saw him next, they did not offer any of these services. No TPRs prompted referrals to SW specifically around these services, and no 30/90 day reviews occurred to determine if there were new DCP needs.

Prior to the implementation of CHER, TPRs routinely prompted clinicians to review the DCP and if needed to refer to SW for an update. TPRs, as currently configured in CHER, do not do this. One recommendation would be to modify the TPR to force a review of the DCP when situations change as should have occurred in this case. Additionally, ensuring that SW staff see class members every 30 or 90 days as required by policy would help to prevent cases like this.

Defendants' efforts have thus far failed to result in compliance with the mandate to integrate services as ordered by this Court in 2014 and again in 2021 with respect to treatment teams in GP. We remain willing to assist in the resolution of this issue.

3. *DCP Form Without Class Member Contact*: In the current cohort, we identified 23 cases (19%) in which the class member either had no DCP or in which the only "DCP" documented was one completed "by chart review," i.e., without the class member's participation.[32]

As discussed in the 48th Report, in the context of the DOC staffing crisis, CHS directed SW staff to complete DCP's by chart review when class members were not available to participate. Because of the ambiguity this introduced, CHS created a new template called "DCP by chart review" to allow for tracking of these cases.

[32] In seventeen cases, no DCP was done, and in six cases, the only DCP in the file was done by chart review only. See discussion in Section IV.C regarding PI 3.3, above.

In their response to the information request for the current report, defendants reported completing an average of 21 DCPs by chart review each month during the last three months of the reporting period. Twenty-seven (43%) of these class members were ultimately released without having received an in-person DCP during their incarcerations.

4. *The "Unexpected Release Form"*: A number of class members in the current cohort were hospitalized at BHPW. In these cases, the class member was nearly always offered an "Unexpected Release Form" shortly after admission, which they often are too symptomatic to sign or refuse to sign. These forms have pre-printed aftercare plans that include, in all cases, the Bellevue Men's Shelter, the Bellevue outpatient walk in clinic, the HRA Job Center on East 16th Street, and the SSA Field Office at Second Avenue and 40th Street. Rarely do staff individualize these forms, and even more rarely do they reoffer the form or any other type of discharge planning later in a hospitalization when the class member has stabilized clinically. These forms do not include any consideration of case management or supportive housing. See, for example, cases 36, 90, 121.

   By contrast, in case 33, the class member remained hospitalized for a number of months, through the end of his incarceration. During this period, he engaged in the development of an ATI, with the assistance of the hospital SW. He was reoffered the Unexpected Release Form later in his hospital stay, but he refused to sign it "give[n] that he has opted to engage in a more personalized discharge plan."

   The SW's statement acknowledges that the Unexpected Release Form is not a Discharge Plan, as HHC informed us years ago and as indicated in their current

Policies 4 and 9. The purpose of the Unexpected Release Form is to provide class members with basic services that they can access should they be released unexpectedly and before the hospital staff have the opportunity to engage in more formal, individualized discharge planning efforts with their patient, as required by the Stipulation. We encourage H+H to consider these comments and reorganize their discharge planning efforts going forward.

5. *Capacity and Willingness of Programs to Accept Class Members*: We have previously stated how important it is to devise a workable solution for defendants to fulfill their obligation to attempt to ensure that a program to which they are referring a class member has the capacity and willingness to accept referred class members (¶¶44 and 46). Eighteen cases were inappropriate solely due to defendants' failure to contact programs to which they were referring class members.[33]

   Cases 91 and 140 are examples of why having current information as to a program's capacity and willingness to accept referrals is important to ensure adequate discharge planning. These class members were referred to Bellevue and to the Bridge, respectively, both former A list providers that might reasonably be expected to accept class members. In case 91, upon learning that Bellevue was not accepting new patients, SW provided an appropriate referral to Metropolitan Hospital Center. In case 140, SW contacted and confirmed that the Bridge would accept the referral at the time of the DCP in September, but when they contacted the program again on the day of release in December, they were informed that the program was no longer accepting new patients. Because of other efforts, the class member was assigned to an ACT

[33] Cases 2, 3, 7, 25, 31, 37, 52, 59, 66, 79, 89, 92, 94, 95, 112, 116 134 and 137. In addition, in cases 10, 12, 28 and 117, there was no finding of inappropriateness for this reason because a subsequent ATI superseded the earlier DCP.

program shortly after release, which rendered the case appropriate for the purposes of our report.

6. *Role of ATI in Appropriateness Determinations*: Many class members engage with outside agencies during the course of their incarcerations. These agencies may include legal actors (e.g., mental health courts, parole, criminal defense counsel) or clinical/social services actors (e.g., TASC, Osborne, Women's Community Justice Project). DCP is often "taken over" by these actors. At times, the DCP is mandated by the court or by parole. Our approach to all of these cases, which we lump into the term "ATI," is to review the extent to which SW coordinates with any requirements of the outside actor. If SW provides what the outside agency requires to effectuate the ATI, we view the work of SW as appropriate. This requires that SW remain engaged with class members over the course of their incarcerations in order to react to the class members' changing situations with regard to the ATI and to any requests made by the ATI. The following analysis demonstrates defendants' compliance when considering the discharge planning developed directly by CHS and then when considering the intervening ATI involvement:

Table 10: Change in compliance after consideration of ATI intervention

	Appointment/Referral		Case Management		Supportive Housing	
	PreATI	ATI	PreATI	ATI	PreATI	ATI
Appropriate	39	61	42	39	27	20
Inappropriate	75	61	25	20	24	20
Ineligible	10	2	57	65	73	84
Total	124	124	124	124	124	124
Compliance	34.2%	50.0%	62.7%	66.1%	52.9%	50%
Change	**+15.8%**		**+3.4%**		**-2.9%**	

The intervention of an ATI increased defendants' compliance by nearly 16% for appointment/referral and by 3.4% for case management, while reducing their performance by 2.9% for supportive housing.

Systems Barriers to Discharge Planning

Given the nature of the crisis facing defendants as well as ongoing systemic barriers to successfully implementing discharge planning, we note two important impediments to the fulfilling of the essential goals of the Stipulation. We understand that although they have a stake in achieving a resolution, defendants cannot unilaterally solve and under the Stipulation are not responsible for solving these systemic problems.

1. *Supportive Housing*: A shortage of supportive housing continues to hamper defendants in assisting class members with obtaining needed housing resources.
2. *Waitlist for assignment to ACT and other higher levels of case management*: Chart reviews indicate that some of the more seriously mentally ill class members—those eligible for higher levels of case management and intensive treatment upon release—face disruptions in their post release treatment because they are not assigned to case management or ACT teams promptly upon release. Instead, they are assigned to CRAN and/or care coordination which, while helpful to many class members, do not provide direct treatment and do not offer the intensity of engagement required by more severely impaired class members.

   We understand that ACT and other high-level services are a scarce resource, and we understand why DoHMH does not assign an incarcerated person without a known release date to a team. Nonetheless, extended waitlists for these services means that some class members receive discontinuous care of insufficient intensity in the weeks following release—a time of significantly increased risk for bad outcomes including death.

DoHMH, which plays a key role in the assignment of ACT, FACT and IMT services, is a defendant agency. While not an enumerated requirement of the Stipulation, the timely assignment of case management and ACT slots is critical to the successful transition to the community for class members with severe impairments. We previously recommended that CHS work with DoHMH to seek the needed funding to expand class members' prompt access to ACT and other higher levels of case management upon release in order to:

- expand the role of CRAN to include more intensive forms of case management,
- develop new specialized programs focusing on class members at and after release, and/or
- expand existing services such that class members would have more access to those services.

On March 28, 2022, we attended a training provided by DoHMH regarding their new demonstration project, CONNECT (Continuous Engagement between Community and Clinic Treatment, see section III.B above). According to the training material, "CONNECT enhances and expands the capacity of existing licensed Article 31 mental health clinics in the following ways:

- "Engages the clinic's surrounding community in the development and design of clinic services (initial and ongoing conversations with the community);
- "Welcomes walk-in clients;
- "Intakes new clients recently released from New York City jails within one hour of walking into clinic during all hours that clinic is open;[34]
- "Provides Medication Assisted Treatment (MAT) for substance use or misuse;
- "Provides clinic services in the field (in people's homes or non-clinic community locations), including medication management, psychotherapy or crisis intervention and outreach;

[34] All nine of the clinics are open during the week, and some of them have extended evening hours on at least some weeknights. Six of the clinics have weekend hours, four on Saturdays, and two on Sundays.

- "Provides open group treatment in which participation occurs regardless of an individual's consistency in attendance; [and]
- "Provides non-clinical support services identified by the community as important to community mental health and quality of life."

During the training, DoHMH indicated that the target neighborhoods include those with:

- "Higher suicide rates
- "Greater depression prevalence
- "More frequent psych ED visits and inpatient psych stays
- "More referrals to mobile crisis teams
- "More referrals to mobile treatment services
- "Higher COVID case rates and mortality, chronic illness
- "Higher rates of poverty and more overcrowded housing."

These neighborhoods include

- Manhattan (Lower East Side, East Harlem)
- Brooklyn (East New York, Crown Heights, Williamsburg)
- Bronx (Mott Haven, Highbridge)

The demonstration project also focuses on people leaving jail, due to the difficulty this population has in accessing the levels of clinical care that they need. Services will be provided in the Article 31 clinics and also where recipients live, though at a lower intensity than ACT or IMT services. Additionally, these clinics will serve people regardless of immigration or insurance status. Because this is a demonstration project, CONNECT targets people in the specific neighborhoods; if successful, DoHMH hopes to expand the model to other parts of the city. SW and CRAN attendees at this training were encouraged to utilize the referral form provided to make referrals to the various clinics utilizing the CONNECT model, but also to advise class members that they could walk in even without documentation or a referral. It remains to be seen how effectively these programs can serve the needs of class members who await placement in ACT or IMT during the early weeks after they are released from jail.

That said, it is commendable that the city is exploring innovative approaches to meet the needs of class members after release, while also providing resources to some of the most under-resourced areas of the city. We recommend that CHS provide SW and CRAN staff with materials that they can give to class members to explain the clinics, including what services they provide and when they can go to these locations for walk-in services.

* * * * *

Summary: Defendants continue to work to improve their assessment and discharge planning capabilities. Viewed longitudinally, these efforts have borne fruit. Defendants can point to many positive developments over time in the CHS program both structurally and in terms of individual practices. However, recent findings indicate a significant deterioration in compliance. Most notably, a substantial number of class members were released without ever having received a CTP or a DCP, largely related to the crisis situation under which defendants were operating during much of the reporting period.

E. **Social Security Benefits**

Subject: Paragraph 87 of the amended Stipulation requires defendants to assess class members' eligibility for Social Security Benefits and to assist eligible class members in obtaining these benefits.

Key References: ¶87; Social Work and Re-Entry Procedures Manual Section 3.11; H+H policy 12; Report 48, pp 61-64.

1. New Applications

Defendants define eligibility for this service as follows:

- SMI,
- Sentence date 30-120 days in the future,

- Ineligible for SSI reinstatement, and
- Consent to release information to SSA.

Performance: Defendants provided data indicating that there was one class member who met the above criteria, to whom they provided assistance in completing the SSA application. Seven other eligible class members declined assistance, for various reasons, including:

- Preference to follow up on their own (three class members)
- Has active benefits (one class member)[35]
- Preference to have CRAN assist after release (one class member)
- Does not need assistance (one class member)
- No reason provided (one class member)

Case 38 was eligible for assistance with a new SSA application but was listed as "not in timeframe" in the New Application data. He was a very impaired class member with prior ACT involvement and numerous psychiatric hospitalizations, including a recent Kirby admission for trial incompetency. He reported no prior SSI history at the time of his admission. His instant admission lasted only 80 days, well within the SSA-mandated timeframe for assistance with an SSI application. He should have been offered an application and, if he agreed, assistance with its completion.

2. Reinstatement

Defendants define eligibility for this service as follows:

- Known date of release,
- SMI,
- Had SSI suspended or terminated during the incarceration, and
- Consent to release information to SSA.

[35] This class member should have been on the reinstatement dataset, not the new application dataset.

Performance: Defendants provided data indicating that there were 17 class members who met the above criteria, and who they assisted in obtaining appointments for reinstatement after release. They identified one class member whose SSA benefits remained active, confirmed by SSA, and for whom no action was needed.

Monitoring Issues: While not all are eligible for SW assistance with SSI reinstatement, there continues to be a high prevalence of self-reported SSI recipients among the sample of charts we review. During July-December 2021, at least 43[36] (35%) of the 124 records we reviewed included documentation that the class member reported active or pending SSA benefits prior to incarceration. Three[37] of these class members were both SMI and sentenced at some point during their incarceration rendering them eligible for reinstatement. Of these three, only case 9 appears on defendants' reinstatement dataset, which notes an appointment at the Field Office a few days after his release, and which also indicates that he was advised to call the Field Office as in-person services were on hold due to the COVID pandemic. Neither case 105 nor case 150 appears on this dataset, though case 150 appears on the New Application dataset, where he is listed as having declined assistance with a new SSA application.

* * * * *

Discussion: Defendants' continued conflation of the data regarding SSA applications and reinstatements has continued for many reporting periods. The two datasets historically provided by defendants each month do not accurately report on the work done by their

[36] Cases 12, 13, 14, 15, 17, 21, 23, 24, 27, 29, 32, 36, 40, 42, 69, 70, 72, 77, 79, 82, 90, 91, 92, 96, 98, 104, 105, 106, 110, 111, 118, 119, 129, 139, 140, 142, 143, 144, 145, 146, 149 and 150.
[37] Cases 9, 105 and 150.

staff. Defendants continue to demonstrate difficulty discriminating between class members who require a new application from those who require reinstatement of an existing benefit.

In August 2020, Defendants informed us that:

> "Social Work has created two new forms in CHER to document and track SSA benefits: 1) the SSA Benefits Offer Form, which indicates whether or not the patient was offered and/or accepted reinstatement, and whether he/she accepted and if not, an explanation of the reason; and 2) the SSA/New Telephone Interview Form, which indicates whether the patient was offered a telephone interview if he/she never had SSI/SSD but meets eligibility criteria. It also indicates whether the telephone interview was conducted, and if not, why not…. Once the forms… are finalized, IT will generate a report indicating who has accepted assistance securing or reinstating SSA benefits" (Response to information request, Report 45).

While a positive development, this intervention does not appear to have resolved the issues we have noted previously and continue to observe. That said, based on our current chart reviews, SW appears to be somewhat more attuned to class members' needs vis-à-vis their SSA benefits.

Unfortunately, SSA is unwilling or unable to enter into a data-sharing agreement, which might have been a mechanism to identify class members who are eligible for reinstatement more accurately. However, on November 25, 2019, we received a draft Pre-Release Agreement from defendants. On March 4, 2020, SSA sent a draft MOU to SSA and requested a demonstration of the online application. "In November 2020, SSA informed CHS that they are reviewing CHS' comments on the drafted pre-release agreement to determine how to proceed. SSA's response is still pending" (Defendants' response to information request, Report 49).

Recommendations: Defendants need to provide support with SSA applications and reinstatements to all eligible class members, and they need to begin reporting accurately and completely on these services.[38]

F. **Veteran's Benefits**

Subject: Paragraph 87 of the amended Stipulation requires defendants to assess class members' eligibility for Veteran's Benefits and to assist eligible class members in obtaining these benefits.

Key References: ¶87; Social Work and Re-Entry Procedures Manual, Section 3.12.1; H+H policy 12; Report 48, p 64-65.

Performance: Defendants provided datasets indicating that no veterans were identified during the current reporting period.

In our appropriateness reviews, we continue to identify occasional class members whose records indicate military service. During the current reporting period, cases 40, 117 and 150 reported military experience. In case 40, the class member reported prior treatment and case management at the VA during his intake, and he was referred to the Manhattan VA for aftercare. In case 117, the class member interviewed with VJO, and the VA confirmed both his military service and his honorable discharge. In case 150, SW documented confirmation from the VA that he was eligible for and had previously received services at multiple VAs around the country.

None of these cases appear on defendants' VA datasets, indicating that defendants are not properly capturing information related to class members' military history. Defendants

[38] In their comments to the draft of this report, class counsel urged us to find defendants "noncompliant with the obligation to assess class members' eligibility for Social Security benefits," given their continuing inability to properly report on class members' status vis-à-vis SSA benefits.

should examine this issue and devise remedial actions to improve their recognition of and reporting on this subset of class members who have specific needs vis-à-vis DCP. [39]

As noted above in Section III.B, CHS conducted a training on Veteran's benefits scheduled for May 18, 2022. Three participants, all from BHPW, attended.

G. **DHS Placement Directly in Program Shelters**

Subject: According to the Stipulation at ¶96, DHS is to "use best efforts" to place class members who meet the following criteria directly in program shelters:

- Sentenced;
- Further assessment in intake shelters is "not necessary after review of the information obtained by defendants during the class member's incarceration;"
- Bed availability; and
- "Arriv[al] at DHS shelter on his or her Release Date prior to the facility's curfew hour."

Further, class members who are SMI "shall be presumptively eligible for placement in a Program Shelter or Mental Health Program Shelter."

Key References: ¶96; DHS policy 02-429 (June 28, 2006 Revision); MOU between DoHMH and DHS (August 4, 2008); Report 48, pp 65-67; Supplement to the Forty-Fourth Report, p. 6 and Exhibit 1.

Compliance: During this reporting period, 59 class members presented to the DHS shelter system (10 per month), an 80% monthly decrease from the 200 class members who presented to shelters during the 42nd reporting period (50 per month).[40] Of these 59 class members, 25 (42%) were SMI and 6 (10%) were sentenced. Two (3%) of the class

[39] In their comments, class counsel urged us to find defendants "noncompliant with the obligation to assess class members' eligibility for veteran's benefits," given their apparent continuing inability to properly report on class members with military histories.

[40] Class counsel suggested that "Defendants should examine the 80% decrease in the number of Class Members presenting to shelters… to determine whether there is an error in the reported data and if not, whether this decrease is consistent with an overall drop in shelter use between 2019 and 2021" (Class counsels' comments, Report 48).

members presenting to shelters were both SMI and sentenced. Their placements upon presentation to DHS are summarized in the table below:

Table 11: Placement of Class Members in Shelter System

	Both Sentenced and SMI (N=2)		NOT both Sentenced and SMI (N=57)	
Placed in	Day of release	After day of release	Day of release	After day of release
Program Shelter	0	1	3	20
I/A Shelter	0	1	5	29
% placed in program shelter	n/a	50%	38%	41%

No eligible class members presented on the day of release. One eligible class member presented two days after release and was placed directly into a program shelter. The other eligible class member presented one day after release and entered an I/A shelter because he did not present on the day of release.

Nineteen of the class members who presented initially to the I/A shelter were later transferred to program shelters, between 2 and 34 days after their entry into the shelter system.

Regarding the five class members who presented on the day of release but who were admitted to I/A shelters, three were SMI and none were sentenced. No reasons were provided as to why they were not provided with a program shelter placement on the day of release.

As discussed in detail in the Supplement to the Forty-Fourth Report and at page 101 of the Forty-Fifth Report, defendants' datasets regarding DHS direct placement into program shelters have been incomplete for at least the past five reporting periods. While defendants indicated that they fixed the issue of pulling cases from both CHER and eCW, the continuously falling number of cases suggests otherwise, Defendants now report that "CHS IT has identified the problem, which was related to the backend logic of the report

and is now in the process of rectifying. CHS will provide an update when complete" (Defendants' response to information request, Report 49).

Therefore, we can only make tentative findings. Based on the best available data, defendants appear to continue to meet the standard of using best efforts to place sentenced SMI class members directly into program shelters when they present on their release dates. Moreover, class members who do not present on the day of release or who do not meet all of the inclusion criteria also frequently are placed directly into program shelters. This supports our conclusion that the limiting factor for direct placement in program shelters is bed availability at those shelters.

The incomplete data presented and analyzed here tentatively indicate that DHS has exerted best efforts to place as many class members into program shelters as possible when CHS made them aware of individual eligible class members.

H. **Time of Release**

Subject: Defendants are obligated to release all class members during daylight hours and in no event earlier than 8:00 a.m., with the only exceptions being those who are released directly from court, after posting bail, or pursuant to a court order requiring immediate release.

Key References: ¶32; DOC Operations Order 03/03 (June 2, 2003); Operations Order 11/18 (November 21, 2018); Report 48, pp 67-68.

Threshold/Expectation: 99%

Compliance: During the current reporting period, defendants released 146 of 150 (97%) eligible class members during daylight hours.[41] Two class members were released late from RNDC in November and December, and two were released late from OBCC in July.

[41] One class member was released to the community from the forensic units during daylight hours.

Defendants were noncompliant for the obligation to release class members to the community during the current review period.

Discussion: In their comments to the draft 48th report, class counsel noted the significant drop in the number of class members eligible for daytime release. In the 42nd report, approximately 110 eligible class members were released each month. This dropped to approximately 26 class members per month in the 48th reporting period. During the current reporting period, an average of 25 eligible class members were released each month. Class counsel also noted that approximately 145 class members each month were eligible for medications and prescriptions on release.

Defendants provided the following explanation:

> "DOC's data is based only those Brad H. inmates subject to the time of release requirement (i.e., those with known release dates which consists of City-sentenced inmates). These tend to be low level offenders, and there appear to be fewer of those now than in the past. Additionally, CHS's data includes all Brad H. releases, including bail releases, court ordered releases, releases to state hospitals, etc. - i.e., whether they had a known release date or not. This accounts for the discrepancy in the data" (email from defendants' counsel, December 21, 2021).

Next Steps: Because the threshold for this foundational measure is stringent, we have judged defendants to be compliant when they have come within striking distance of the threshold. However, defendants have now been noncompliant for four consecutive reporting periods, even as the number of class members eligible for daytime release has dropped, and we recommend that they explore and report on the reasons their compliance has dropped.

I. **Parole Violators**

Subject: Under the Stipulation at ¶32, all class members who are released through mechanisms other than bail or pursuant to a Court order requiring immediate release are

entitled to release during daylight hours, and, if SMI, to an offer of transportation to their place of residence or a shelter. Defendants are also required under ¶45 to provide an appointment for aftercare to those whose release date is known or becomes known to SW staff in advance of the class member's release from incarceration.

The amended Stipulation at ¶32.1 explicitly addressed the discharge planning needs of "Class Members held solely pursuant to an alleged parole violation." Defendants are to:

> "use best efforts to release such Class Members from incarceration during daylight hours; provided, however, that where a non-DOC escort is required as a condition of release…, Defendants shall reasonably prioritize and make best efforts to release such Class Member from incarceration with sufficient time to be escorted to his or her assigned treatment program or residence."

In cases where these timeframes for release cannot be met, "DOC shall document the circumstances resulting in the delay."

Key references: ¶¶32, 32.1, 45, 101; DOC Operations Order 03/03 (June 2, 2003); Operations Order 11/18 (November 21, 2018); Report 48, pp 68-69.

Compliance and Discussion: Because the amended Stipulation requires "best efforts," we have neither created a PI nor set a threshold for compliance.

On May 25, 2022, during the comment period for this report, defendants provided data indicating that during the reporting period, defendants released 165 (42%) of 389 parole violators during daylight hours, which they define as the hours between 8am and 5pm. The dataset does not include any documentation as to the circumstances resulting in the delayed releases for any of the 224 class members released after 5pm. Furthermore, there is no information regarding class members requiring escort to programs, nor is there information regarding DOC's efforts to "reasonably prioritize" these cases for timely release.

In the coming reporting period, we will request further information regarding the following questions:[42]

1. Why has DOC chosen 8am-5pm as their definition of "daylight hours?"
2. When will DOC provide data that includes information as to the reasons for releases occurring outside of daylight hours?
3. When will DOC provide data that includes information regarding their "best efforts to release… Class Member from incarceration with sufficient time to be escorted to his or her assigned treatment program or residence?"

V. Conclusion

The overall dysfunction in the city jails, especially decreasing levels of production of class members for MH and SW appointments, has contributed to a deterioration in defendants' compliance with basic tasks. Delays in completing mental health assessments, CTPs and DCPs lead to an increase in the number of class members released without, or with significantly delayed, treatment and/or discharge plans. Until defendants resolve this crisis, it will be extraordinarily difficult for them to come into compliance with many aspects of the Stipulation.

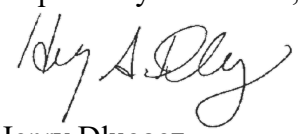
Additionally, until a data dictionary, crosswalk and coding are finalized, we remain unable to make unqualified determinations concerning compliance in many important areas covered by the Stipulation.

This concludes our Forty-Ninth Report, which summarizes our findings and conclusions regarding a number of aspects of defendants' obligations under the Stipulation, including the quality or "appropriateness" of the services provided, the reliability of defendants' data and their performance in a variety of areas.

[42] In their comments, class counsel urged us to find defendants out of compliance with ¶32.1 as they had not provided any data at the time of the draft report. Defendants have now remedied that failure, but the data is incomplete as we explained. These questions are designed to help us understand whether defendants have fulfilled their obligations as outlined in ¶32.1.

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

Respectfully Submitted,



Henry Dlugacz
Compliance Monitor

Erik Roskes
Compliance Monitor

EXHIBIT 1

Modified Performance Goals

PI			Previous	New Thresholds		
#		Description	Threshold	Category	Threshold	Change
1.1		Timely initial assessment	95%	Critical	95%	0.00
3.1.1		Timely CTP in MO	95%	Key	90%	(0.05)
3.1.2		Timely CTP in GP	95%	Key	90%	(0.05)
3.3		Timely DCP	95%	Key	90%	(0.05)
4.1		Timely Medicaid prescreen	95%	Key	90%	(0.05)
4.1.2		Timely prescreen at CRAN	95%	Standard	85%	(0.10)
5.1		Timely Medicaid application	90%	Key	90%	0.00
5.2		Medicaid application at CRAN	95%	Standard	85%	(0.10)
5.3.1		MGP on release	90%	Standard	85%	(0.05)
5.3.2		MGP at CRAN	90%	Key	90%	0.00
6.1		Timely Medicaid activation	95%	Key	90%	(0.05)
6.2		Timely Medicaid unsuspension	95%	Key	90%	(0.05)
7.1.1		Medications/prescriptions on release	90%	Critical	95%	**0.05**
7.1.2		Medications/prescriptions at CRAN days 0-14	90%	Critical	95%	**0.05**
7.1.3		Medications/prescriptions at CRAN days 15-30	90%	Critical	95%	**0.05**
8.1		Appointments	95%	Key	90%	(0.05)
8.2		Appointments at CRAN	95%	Key	90%	(0.05)
8.3		Referrals	95%	Key	90%	(0.05)
9.1		Emergency benefits	100%	Critical	95%	(0.05)
9.2		Timely Public Assistance applications	95%	Key	90%	(0.05)
9.3		Public Assistance registration	95%	Standard	85%	(0.10)
10.1		HRA applications	95%	Key	90%	(0.05)
10.2		Forwarding of 2010e approvals	95%	Key	90%	(0.05)
11.1		Transportation from jail	95%	Key	90%	(0.05)
11.2		Transportation from CRAN	95%	Key	90%	(0.05)
12.0.1		Follow up: appts, jail	95%	Standard	85%	(0.10)
12.0.12		Follow up: referrals, jail	90%	Standard	85%	(0.05)
12.0.2		Follow up: housing, jail	99%	Standard	85%	(0.14)
12.0.3		Follow up: adequacy of housing, jail	95%	Standard	85%	(0.10)
12.1		Follow up: appts, CRAN	95%	Standard	85%	(0.10)
12.2		Follow up: referrals, CRAN	90%	Standard	85%	(0.05)
12.3		Follow up: housing, CRAN	99%	Standard	85%	(0.14)
12.4		Follow up: adequacy of housing, CRAN	95%	Standard	85%	(0.10)
2.4	Appropriateness Measures	SMI	95%	Key	90%	(0.05)
3.2		Appointment/Referral	90%	Key	90%	0.00
3.2		Case Management	90%	Key	90%	0.00
3.2		Supportive Housing	90%	Standard	85%	(0.05)
TBD		Daytime discharge	99%	Critical	95%	(0.04)

EXHIBIT 2

CASE SUMMARIES

Case 1, July GPMEDS108, was a 37 year old man who was incarcerated from September 3, 2020 until July 2, 2021. He was housed in GP at the time of his CTP, where he was diagnosed with schizoaffective disorder; he was considered SMI. His CTP on September 16, 2020 was timely, but his DCP on October 5, 2020 was 10 days late. At this DCP, he was referred to Fortune Society, but he declined a referral to CRAN. He reported that he was not homeless, having previously been housed at Fortune Society.

CRAN was aware of the class member from a referral during his previous incarceration, in June 2020. They learned of his rearrest and reached out to jail staff on September 22, 2020. They met with the class member via video on October 11, 2020, and they remained involved in his case through his release on July 2.

SW completed a 30-day follow up on January 21 in response to an inquiry by Urban Justice Center (UJC). During this follow up, he refused assistance with an HRA 2010e but expressed continued acceptance of a referral to the Fortune Society. SW attempted to contact the Fortune Society on a number of occasions, including on March 16. The class member spoke with a case manager there on March 25. The class member was originally diagnosed with schizoaffective disorder, with borderline personality disorder added subsequently. A TPR of March 21 changed the diagnosis to only borderline personality disorder and he was determined to be SMI-No based solely on this change in diagnosis. It was noted that he had not shown any signs or symptoms of schizoaffective disorder and that the class member continually used K2 while on the unit which accounted for his bizarre behaviors. The possibility that his prescribed medications attenuated his symptoms was not addressed, and a functional assessment was not performed. Psychiatry adopted the diagnostic change but continued to prescribe Risperidone, Buspar, and Remeron.

SW saw the class member again on the day of his release, July 2, and confirmed his bed at Fortune Society. He was provided with an ACL which he signed. SW notified CRAN of his release to Fortune Society.

The SMI determination was rated as inappropriate because he was changed to a category 3 diagnosis without documentation of the absence of significant functional impairment or clinical distress, without adequately considering the possible attenuating effect of the medication prescribed by the psychiatrist and in the face of highly problematic behaviors both during his incarceration and while he was living in the community. Although no CRAN referral was made during the instant incarceration, he was previously connected with CRAN, with whom he remained involved. Case Management was rated as appropriate as a result.

A suggested focus for remediation is to ensure that staff are trained and directed to document functional assessments so that when a change is made from a category 1 or 2 diagnosis to a category 3 diagnosis, there is a basis for an SMI determination.

Findings:

Referral/appointment: appropriate
SMI: inappropriate
Case Management: appropriate
Supportive Housing: ineligible

Case 2, July GPMEDS129, was a 22 year old man who was incarcerated from November 5, 2020 to July 15, 2021. He was housed in GP at the time of his CTP, where he was diagnosed with adjustment disorder and substance use disorders (SUDs); he was not considered SMI. Both his CTP, on November 28, 2020, and his DCP, on December 2, 2020, were timely.

SW conducted a 90-day follow up on March 10 which did not result in any changes to the DCP. The patient mentioned a possible ATI. During a medication reevaluation on May 19, there was some suggestion of a possible trauma related disorder, but this did not result in a change of diagnosis. Although the significance of his trauma symptoms should have been further clarified, it was not likely that this would have led to a change in his SMI designation. There were numerous notes indicating that the class member was not produced for appointments which required "bridge orders." The record contained only two TPRs, on December 15, 2020 and February 19, 2021.

The class member was referred to Bowery Residents Committee which was not contacted to ascertain the program's willingness and capacity to accept the referral.

The class member's prescriptions were sent to a pharmacy in Brooklyn even though he lived on the Lower East Side of Manhattan. Although the location was not near his housing, the class member requested this pharmacy; the referral was not deemed inappropriate for this reason.

Findings:

Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 3, July GPMEDS156, was a 22 year old man who was incarcerated from February 6 to July 21. He was housed in GP at the time of his CTP, where he was diagnosed with other specified disruptive, impulse-control, and conduct disorder and adjustment disorder, rule out other specified bipolar disorder and cannabis use disorder; he was not considered SMI. Both his CTP, on March 15, and his DCP, on March 22, were timely. He was referred to Bellevue outpatient and was given a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

A SW note on April 21 noted that the class member wanted continued mental health treatment and reviewed the DCP of March 22. An ACL on the day of release reiterated the referral to Bellevue Hospital Center, but again the program was not contacted to ascertain its willingness and capacity to accept the referral.

Findings:

Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 4, July GPMEDS158, was a 19 year old man who was incarcerated from March 1 to July 15. He was housed in GP at the time of his CTP, where he was diagnosed with other specified trauma and stressor disorder, rule out post-traumatic stress disorder (PTSD); he was not considered SMI. His CTP, on March 30, was 12 days late. The initial effort to complete a DCP,

on April 8, was timely but the class member could not be seen in person due to "security concerns;" instead the form was completed without a face to face assessment of the class member.

MH staff attempted to assess this class member on numerous occasions, but he was not produced by DOC. In an attempt to secure a psychiatric evaluation, on April 21 they ordered his transfer to C71. The class member had not been transferred as of April 29 when the same prescriber documented their repeated attempts to effectuate the transfer. The transfer was never accomplished, but on April 30 the prescriber did see the class member and indicated a disposition of general population with follow up.

A court collateral note of May 26 indicated that the class member's defense counsel expressed concern about his lack of access to treatment. The class member was not produced for medication related contacts on May 28 or June 7 leading to "bridge orders." He had no complaints during a TPR of June 14. No referral was made to SW for an updated DCP and there was no indication that the clinician had reviewed the initial DCP. DOC did not produce the class member for requested clinical contacts on June 17, June 24, July 1, or July 7 leading to more "bridge orders" for his expiring medications.

The referral was inappropriate because there was no SW follow up after the initial (insufficient) attempt to complete the DCP. This case illustrates the problems associated with the completion of a DCP form without seeing the class member, the lack of SW follow up during the course of his incarceration, the significant disruption caused by problems with production, and the insufficient review of the DCP by clinical staff during TPRs, all of which contributed to the inappropriateness of the referral.

Findings:

Referral/appointment: inappropriate (no DCP, no SW follow up after the initial attempt to complete the DCP)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 6, July GPNOMEDS132, was a 60 year old man who was incarcerated from November 14, 2020 to July 14, 2021. He was housed in GP at the time of his CTP, where he was diagnosed with adjustment disorder, other specified personality disorder, and SUDs; he was not considered SMI. Both his CTP, on December 2, 2020, and his DCP, on December 11, 2020, were timely. He was referred to ACI Chemical Dependency Treatment Center. SW attempted to contact the program to confirm he could return there for care, and they provided him with a referral form.

The initial mental health assessment noted a history of referral to Bellevue in 2010 after refusing medical intake, during which time he presented as tangential, labile, and rambling. During a 2019 incarceration he tied something around his neck in intake. His CTP during this incarceration suggested significant functional impairment, indicating that he was diagnosed with other specified personality disorder due to a "pervasive pattern of manipulative behavior, impaired interpersonal relationships" and a "grandiose self-image and poor insight." The class member appeared to improve behaviorally during his incarceration, suggesting that the functional impairments noted shortly after his admission were likely connected to substance use and withdrawal.

A SW 30-day follow up on March 18 found no need to revise the DCP. Although a previous attempt had been made, the SW did not renew attempts to contact his prior treatment provider to ascertain if he could return. According to IIS he had a projected release date of July 14, but SW did not provide him with an appointment. One focus of remediation would be to encourage SW staff to fully review the DCP and follow up on loose ends, such as the attempted but unsuccessful contact with the community-based provider at the time of the initial DCP.

Findings:

Referral/appointment: inappropriate (no appointment provided to sentenced class member)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 7, July GPNOMEDS196, was a 36 year old man who was incarcerated from May 18 to July 13. He was housed in GP at the time of his CTP, where he was diagnosed with other specified trauma and stressor disorder; he was not considered SMI. His CTP, on May 26, was timely.

On June 3, SW attempted to complete a DCP, but the appointment was cancelled by CHS. SW attempted to see him the following day, but he had been transferred to AMKC. On June 7 and 8, DOC did not produce the class member when requested by SW. On the June 8, 4 days after it was due, a DCP was completed but he refused to engage with SW. A TPR of June 23 indicated the class member planned to relocate to South Carolina where his children live. SW saw the class member on July 1, and he requested two referrals; he was given referral forms for both Fortune Society and Exodus outpatient for substance use treatment. Neither program was contacted to ascertain that they had the capacity or willingness to accept the referral. There was no indication that SW inquired about or was aware of his stated desire to move to out of state; because he was on parole, we did not consider this a reason to find the case inappropriate.

Findings:

Referral/appointment: inappropriate (no contact with programs)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 8, July MO22, is a 56 year old man who was incarcerated from November 16, 2020 to July 15, 2021. This includes an incarceration from November 16, 2020 to March 30 where he was discharged and immediately rearrested and incarcerated again from March 30 until July 15, 2021. This summary reviews both as one continuing incarceration. He was housed in MO at the time of his CTP, where he was diagnosed with other specified trauma and stressor disorder and alcohol use disorder; he was not considered SMI. Both his CTP, on December 15, 2020, and his DCP, on December 22, 2020, were timely.

A court collateral note of December 3, 2020 shows that Legal Aid Society (LAS) requested a mental health referral based on the class member's self-report of a PTSD diagnosis, his report that he was taking psychotropic medications prior to incarceration, and because he reported having not received mental health treatment during his incarceration.

The initial mental health assessment of December 8, 2020 concluded that his primary diagnosis was PTSD, evidenced by his reported history of trauma, symptoms of hypervigilance, sleep disturbance in the form of nightmares, changes in world view, angry outbursts, irritability, avoidance, and substance use. He was found at this time to be SMI yes. The CTP notes a diagnosis of other specified trauma and stressor disorder and that the class member was prescribed prazosin. The assessment notes the previous PTSD diagnosis based on the class member's reported symptoms, chart review, and history, but found insufficient indications that he met the full criteria for PTSD. He was noted to be able to maintain gainful employment and meaningful relationships. He was not hospitalized, nor was he engaged in community-based treatment. The assessment further noted that his reported symptoms and impairments were exacerbated by his extensive history of alcohol misuse. On December 15, a partial syndrome was documented, and he was reasonably recategorized as SMI no based on this assessment. The psychiatrist saw the class member later that day, and diagnosed him with other specified trauma and stressor disorder, r/o PTSD, prescribing prazosin (There was no prescriber note prior to that date, so it was unclear how the class member was originally started on prazosin).

At his initial DCP, he refused a referral, indicating that he anticipated a parole mandate. No additional SW contacts were present until an ACL on July 15, the day of release, documenting a referral to New Horizon, not far from his home. He was provided with a referral form and an ACL, but the program was not contacted to ascertain its willingness and capacity to accept the referral. His prescriptions were sent to a CVS on Court Street in downtown Brooklyn, far from his residence and treatment location.

Findings:

Referral/appointment: inappropriate (no contact with program, pharmacy distant from his home)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 9, July MO24, was a 49 year old man who was incarcerated from December 12, 2020 to July 2, 2021. He was housed at BHPW at the time of his timely CTP on December 17, 2020, where he was diagnosed with schizophrenia, antisocial personality disorder and substance use disorders; BHPW staff did not document a conclusion as to his SMI status. He refused to sign his unexpected release form on December 17, 2020.

The class member remained hospitalized at BHPW until December 29 2020 where he was started on an antipsychotic and a mood stabilizer. As his condition stabilized, he was returned to jail. Upon return to jail on December 30, 2020, his diagnoses of schizophrenia and substance use disorders were retained, and he was found to be SMI. A CTP was completed on January 6th, but the class member refused to participate. As a result, the CTP was completed by chart review only. It continued to diagnose schizophrenia and substance use disorder and retained the determination that the class member was SMI. A DCP was attempted on January 15, but the class member refused to participate and refused all services. An addendum to the DCP on May 21 indicates that he accepted a referral to CRAN.

On March 10, the CM's defense attorney informed court collateral staff that he was likely to plead to "city time" on his March 15 trial date, and that he would then be released at the end of June. A TPR of March 11 indicated MH staff's awareness of his next court date but not of the

likely outcome as described by the defense attorney. However, the TPR notes that the patient reported that he would be released on June 24, following sentencing. A court collateral follow up on March 18 documented that the class member was sentenced on March 15, and had a projected release date of July 2. SW documented their awareness of this projected release date as of March 24. At that time the class member indicated that he desired an SSI application. (While not documented in the record, the SSA reinstatement data set indicates that staff arranged an appointment for a teleconference with the field office for July 5).

On April 14, the CM reported to SW that the only DCP service he desired was reactivation of his SSI so he could move to Boston or Rhode Island. SW reoffered him applications on June 8, and he accepted public assistance and Medicaid applications; there was no reoffer of mental health treatment or supportive housing at that time. The documentation indicated that the class member was not city sentenced which was inaccurate. There were no 30-day SW follow up notes in his record.

On June 16, the class member inquired of CRAN if he could be connected with an ACT. The CRAN worker informed SW of this via email, inquiring if he might be eligible, but the jail record contains no indication that SW responded to this request.

A DCP update of July 2, the day of release, indicated that the CM accepted an appointment as well as a CRAN referral, and that he refused a HRA 2010e housing application consistent with his continuing plan to possibly return to live in Boston. He received an ACL indicating that staff were sending his prescriptions to Nevins pharmacy in Brooklyn, and that they referred him to ICL Respite.

On July 1, CRAN engaged effectively with the CM. On July 2, CRAN documented that the pharmacy would not honor the prescription because it was written utilizing an AKA which was not the CM's real name. On July 6, CRAN offered to assist the CM with obtaining medications. By July 12, CRAN had contacted the CM at ICL and learned that they had assisted him with medications which were "brought to him." The CM missed his initial appointment at CASES due to being "exhausted" but reported that he planned to attend the following appointment. On July 15, CRAN confirmed that the CM kept his second intake appointment at CASES.

Findings:

Referral/appointment: appropriate (He was given an appt on the day of release. While the pharmacy was quite distant from his provider and his residence, CRAN chart documented that his medications were being delivered)

SMI: appropriate

Case Management: inappropriate (higher level case management should have been at the very least considered given his fairly severe illness, his history of multiple hospitalizations and incarcerations, and his psychosocial needs. SW should have responded to his inquiry of CRAN as to a possible ACT referral)

Supportive Housing: ineligible

Case 10, July MO56, was a 33 year old man who was incarcerated from May 25 to July 1. He was housed in MO at the time of his timely CTP on June 2, where he was diagnosed with schizophrenia; he was considered SMI. He was also provided with a timely DCP on June 2. He was given a referral form to CASES, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral. He was referred to CRAN and to SPOA

for ACT, and he accepted a 2010e application. SW learned on June 15 that he had had an active housing approval good through January 5, 2022.

A June 16 note from the 730 mobile team indicated that the judge would consider releasing the class member if an appropriate DCP was developed. The 2010e approval was forwarded to Project Renewal on June 22 but was not forwarded to any other housing providers. On June 24, CRAN inquired of SW about the status of efforts to secure supportive housing, but SW did not provide them with an update. On June 30, the class member's criminal defense counsel informed SW that they had arranged for his placement at Exodus transitional housing with hotel placement in Brooklyn, and this was confirmed by a letter from Exodus. SW asked SPOA to expedite assignment of case management. The ACL indicates that he was assigned to Visiting Nurse Service Brooklyn ACT team and that he had an appointment on July 1 at 3PM. An additional referral was made to Bridge Back to Life as well on this date. The CRAN records include an email thread showing extensive coordination efforts among the various providers to ensure that he received the ACT placement, transportation to his hotel from court and medication.

The class member's Medicaid status was ambiguous. The record indicates a May prescreen result of "active," but, according to data supplied by HRA, his status was HX-CL [closed on the state exchange] 12/31/99, and his Medicaid was not activated.

***CHS Response**: CHS disagrees with the rating of Case 10 as inappropriate for supportive housing. The requirements were met during a recent, earlier incarceration. Supportive housing was sent to CRAN and two housing providers during his earlier incarceration.*

Monitors' Response: On June 2, the class member agreed to receive assistance with supportive housing. No application was submitted, but on June 15, SW documented the active application from his prior incarceration, as noted above. On June 22, SW emailed the 2010e approval to Project Renewal to "determine if the client is a good fit for transitional or supportive housing at project renewal." Project Renewal did not respond. On June 23, the class member's defense attorney contacted CRAN to ask about the supportive housing process, indicating "that she was ***hoping for assistance in following up with CHS*** about the client's progress with this…. [The attorney] noted that she believes the client interviewing for supportive housing opportunities might bolster his chances at being released at an upcoming court appearance" (emphasis added). On June 24, CRAN emailed SW regarding the attorney's queries regarding the status of the class member's supportive housing application. Thus, although there was an active 2010e from the prior incarceration, SW did not respond to the class member's attorney's request via CRAN to further assist the class member with regard to obtaining interviews for a potential supportive housing placement.

Findings:

Referral/appointment: inappropriate (no contact) → appropriate (ATI)
SMI: appropriate
Case Management: appropriate
Supportive Housing: inappropriate (The approval was sent to one provider, and even when CRAN inquired, SW never informed CRAN as to the status of the application/approval/

referrals. While the Exodus hotel was useful in the short term, it is transitional and does not obviate the need to fully process the 2010e approval)

Case 12, July MO83, was a 24 year old man who returned to Rikers Island after a 9 month hospitalization at Kirby. He was incarcerated from November 17, 2020 to July 2, 2021. He was housed in MO at the time of his timely CTP on November 20, 2020, where he was diagnosed with schizophrenia and SUDs; he was considered SMI. His DCP on December 3, 2020 was 2 days late; he was provided with a referral form to Richmond University, but there is no indication that SW attempted to contact the provider to determine if they would accept the referral. He was referred to CRAN and to SPOA and AOT. He also accepted a 2010e application which was approved on December 14, 2020 and sent to three housing providers.

A note of December 11, 2020 indicated that he was eligible for SPACT services pending release. SW saw him for 30-day follow up appointments on December 29, 2020, January 28, February 26, and March 26, none of which led to updates to the DCP.

On April 9, the 730 mobile team documented that CRAN was making residential referrals for the CM who had a telephone interview with Phoenix House for residential treatment on April 16. A 30-day follow up contact note from April 28 indicated that he had been rejected by Harbor House and that he was awaiting a response from Phoenix House. Although staff did not confirm this with the CMs attorney, on May 26, the class member reported that his legal team informed him that had been rejected by Phoenix House but that they were exploring possible outpatient programs. The 730 team spoke with CRAN who informed them that he had an interview scheduled with Exodus on June 23 and that he had also been referred to Fortune Society. A 30-day SW follow up note from June 23 recorded this information. A 730 team note from June 30 documented a telephone call with the CM's attorney who indicated that he might be released to Exodus the following day. The 730 team informed the treatment team of this development.

On July 1, SW received notice from an EAC clinical supervisor that the CM was accepted into an ATI with Exodus and was placed in a MOCJ hotel in Brooklyn.

Per SW he was assigned to ENY ACT program on July 1, the day prior to this release. The CM received an ACL indicating the ACT referral, the referral to CRAN, and the hotel placement at the ATI with Exodus.

Findings:

Referral/appointment: inappropriate (no contact) → appropriate (ATI)
SMI: appropriate
Case Management: appropriate
Supportive Housing: appropriate

Case 13, July MO136, was a 43 year old man who was incarcerated from November 20, 2020 to July 16, 2021. He was housed in MO at the time of his CTP on December 10, 2020, which was 2 days late: he was diagnosed with schizophrenia and was SMI. His DCP, on December 22, 2020, was 1 day late; he refused a referral for mental health treatment and for a 2010e in favor of HASA, but he accepted a referral to CRAN.

This CM's initial mental health assessment on November 23, 2020 indicated symptoms of paranoia, lability, and disorganization, and he was transferred to C71. He was assessed by the C71 psychiatrist who returned him to GP the following day with a diagnosis of adjustment

disorder. These moves changed the CTP due date from November 23, 2020 to December 8, 2020. Following reassessment, he was transferred to BHPW on November 29, 2020 where he remained until December 1, 2020. After returning to jail, he was not produced for his CTP of December 7, 2020. At the time he was noted be "destroying his cell and yelling and screaming. This [was] considered a security risk [and the plan was to] reschedule."

SW attempted to see him on December 18, 2020 but "was not allowed on the unit due to safety concerns." SW did contact HASA on December 23, 2020, which indicated that the CM was "not connected to their services."

At his December 24, 2020 TPR, the diagnosis was changed to impulse control disorder, rule out personality disorder, rule out substance use disorder(s), and his SMI status was changed to no. This appeared to be a reasonable assessment of his symptoms but did not address the functional impairments in social and adaptive functioning, relationships, employment, and housing noted at his CTP of December 10, 2020. This CM was also involved with RCS/non-medical case management although they also discussed with him a possible discharge to a BRC treatment program. On March 15, 2021 Legal Aid contacted CHS to request clarification of the CM's diagnosis, not realizing that it was changed from schizophrenia to other specified impulse control/conduct disorder. The TPR of March 26 contained a good explanation of why he did not meet diagnostic criteria for schizophrenia, although the CM's functional deficits again went unaddressed. At that time, he was receiving haloperidol, sertraline, buspirone and benztropine. The TPR concluded that they would continue to meet with him for "diagnostic clarification" and that the team would continue to explore possible revisions to this diagnosis and a "possible change to SMI YES." At his following TPR of May 7, 2021, he was noted to be "calmer" and to be "staying out of trouble." However, by May 25, 2021, his medication adherence was lower, and he appeared more symptomatic and increasingly impulsive.

On June 28, 2021, RCS indicated that he was found to be "suitable for SRO housing," and that the court was requiring him to "report to HASA housing office… for placement as a condition of release," which was anticipated for July 1, 2021. SW noted awareness of this on June 29, 2021, at which point they prepared an ACL listing an appointment with the HASA housing office. There was no indication that a referral for mental health treatment was initiated or that they responded to his earlier refusal. A DCP was created on June 29, 2021 and indicated a known release of July 1, 2021. The DCP also indicated the HASA housing office as the only appointment pursuant to the ATI.

Confusion surrounded his release date and the plans for follow up treatment. On July 6, 2021 the CM told RCS that he "missed his bus for this discharge date of July 1, 2021 to enter BRC's treatment provider [and was] provided with a new date of July 16, 2021." On July 9, 2021 SW documented that he was "not produced to court on July 1" resulting in a new court date of July 16, 2021. On July 13, 2021 RCS noted discussions regarding a "possible" discharge to a BRC treatment program.

No 30/90-day follow ups took place. SW did not reengage with this CM until near the end of incarceration, more than six months after the initial DCP. He was not reoffered a referral for mental health treatment following his initial refusal. There were notes suggesting "possible BRC" treatment but no indication that he would receive adequate mental health treatment through the HASA housing placement he ultimately received. SW neither inquired what mental

health treatment would be available to him at the SRO, nor offered supplemental treatment resources.

***CHS Response**: CHS disagrees with the rating of Case 13 as inappropriate for case management. The determination should be changed to "appropriate" because the discharge planning was appropriate on the basis of Mental Health's determination that the patient was SMI-No. Defendants object to the inappropriate finding because the appropriate social work services were offered for the documented SMI rating and patient's clinical need. We believe the case should only be included in the SMI appropriateness section and not counted against CHS twice for the same finding.*

Monitors' Response: When cases are found to be SMI No and we determine that this is incorrect, the services that should have been offered to an SMI class member but were not will also be rated inappropriate. As we noted in Report 42 and subsequent reports, a finding that the class member is SMI is a predicate for more intensive services, and the failure to properly determine a person to be SMI results in SW not offering those services. While it may often be true that SW did the best they could given the incorrect assessment, defendants did not provide this class member a clinically appropriate discharge plan given his level of need.

Findings:

Referral/appointment: ineligible → inappropriate (no reoffer of MH referral, did not address the inadequacy of his HASA placement to meet his MH needs)

SMI: inappropriate (While MH documented the absence of a symptomatic picture that would be required to support a diagnosis of schizophrenia, they did not address his documented functional impairments or the role that medications may have been playing in helping his symptoms remit. Even after LAS inquired as to his diagnosis, there is no indication that the treatment team met to consider his diagnosis)

Case Management: inappropriate (CRAN closed his case after he was improperly changed to not SMI)

Supportive Housing: ineligible

Focus for Remediation: Treatment team should focus on the assessment of functional impairment, especially when changing from a diagnosis that automatically qualifies as SMI to one which only qualifies as SMI if it results in significant functional limitations or clinical distress.

Case 14, July MO164, was a 36 year old man who was incarcerated from March 7 to July 26. He was housed in MO at the time of his CTP on March 30, which was seven days late. He was diagnosed with schizoaffective disorder and cannabis use disorder; he was not initially considered SMI, but this designation was corrected to "SMI: yes" the next day. His DCP form, completed on April 8, was timely but was completed without his input or participation.

This class member was housed in GP at the time of his initial mental health assessment, making the CTP due within 15 days. Various problems plagued efforts to conduct a timely CTP. He was not produced by DOC on March 21 or March 23, and CHS cancelled his appointments

for CTP due to staffing issues on March 24, 25, 26 and 27. On March 29 he was again not produced. When, on March 30, he was produced, the class member refused to engage, and, as a result, the CTP was completed predominantly through chart review.

The class member left without being seen after being produced for a SW visit to complete his DCP on April 2. Documentation indicates that he was not produced on April 6 and 7 for SW appointments. However, there is also an April 7 declination form indicating that he refused to sign countersigned by a witness. The DCP form was completed on the due date without meeting with the class member due to what were described as "...frequent security concerns on the unit," calling into question the other documentation indicating that the class member refused.

On April 30, court collateral documents the possibility of an ATI agreement. On May 5, documentation indicates that he accepted a referral to CRAN for transitional case management. On June 2, he accepted a referral to his prior provider, Brightpoint/Sun River, as well as an HRA 2010e. A signed referral form was in the record. The HRA 2010e was submitted on June 2 and approved on June 11. SW forwarded the approval to SPOA, AOT and two providers. SPOA placed him on a waitlist for FACT on May 5. The 30-day follow up note by SW on July 2 indicates no change to the DCP but notes CRAN's efforts to obtain an ATI. SW reached out to defense counsel and CRAN for updates, noting that Harbor House was reviewing the class member's application. Harbor House subsequently accepted the class member, sending a letter to that effect on July 9. As of July 22, CHS staff were aware of his likely release on July 26 prompting them to prepare an after-care letter, which reviewed the DCP.

Findings:

Referral/appointment: inappropriate (SW did not meet with CM to make direct offer or get direct refusal) → appropriate (ATI)
SMI: appropriate
Case Management: appropriate → appropriate (CRAN was instrumental in arranging the ATI)
Supportive Housing: appropriate → ineligible (residential ATI)

Case 15, July MO171, was a 20 year old man who was incarcerated from March 30 to July 22. He was housed in MO at the time of his CTP, which was completed 5 days late on April 14; he was diagnosed with other specified trauma and stressor disorder, and intellectual disability (ID) mild and was SMI. His DCP, on May 3, was 10 days late. He was referred to SCO Family of Services, his prior provider, and SW communicated with his previous case manager, but not the program directly. He was also referred to CRAN, but he refused a supportive housing application indicating he would return to his previous SCO group home.

This CM's initial mental health assessment noted his linkage to OPWDD and included a diagnosis of "slight" mental retardation, learning disability and developmental disorder. SW confirmed the connection with OPWDD on April 16, noting that he qualified for their services. The record contained copies of psychological testing reports completed prior to the class member's incarceration at a program geared toward people with intellectual and developmental disabilities. These psychological testing reports documented his low IQ and poor adaptive functioning. They recommended follow up at Heart Share.

He had a "life planning meeting" with a case manager and OPWDD on May 18. A 30-day follow up with SW the following day did not result in any modifications to his DCP; however, at the 30-day follow up of June 4, a referral to NYSTART in Brooklyn (SUS) was added. The

CM's attorney engaged in a telephone conversation with CHS and the CM's care coordinator to discuss community-based services; the attorney also noted that he was working on a bail application. The chart contained a June 30 letter from "Mustard Seed Forensic Community" accepting him for treatment for "…sex offense related behavior." Additionally, on July 5, SUS/NYSTART responded indicating that "OPWDD responded on 6/30/21 and stated they are not able to approve applications for people who are incarcerated. However, upon his release, we were advised to resubmit the application for approval within 24-48 hours."

A 30-day follow up by SW on July 13 noted prior referrals to CRAN, SCO and Mustard Seed and also the plan to refer the CM to NYSTART closer to the end of his incarceration. He was also referred to CASES for "possible monitoring services post-release." The ACL noted his OPWDD service provider and case manager and indicated that a referral was again sent to NYSTART; the CM was encouraged to contact the program after release to enroll. The referrals to Mustard Seed and CASES were also noted. On July 23, NYSTART advised SW that they had accepted the CM and would reach out to him to set up services. The good attention to his specialized need for follow up care, resulted in a rating of appropriate for referral/appointment.

Regarding the CM's SMI status, he was originally designated as SMI Yes but a TPR of April 29 changed to this no without any explanation. Two subsequent TPRs continued this change. However, a June 14 addendum to the June 9 TPR changed the designation to SMI yes because of this functional impairment stemming from his intellectual disability diagnosis. Subsequent TPRs retain this change, so the case was appropriate in this area.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: ineligible

Case 16, July MO181, was a 34 year old man who was incarcerated from April 21 to July 16. He was housed in MO at the time of his CTP, where he was diagnosed with intermittent explosive disorder, substance induced mood disorder, and substance use disorders; he was not considered SMI. His CTP, on June 2, was 21 days late, but his DCP, on June 10, was timely; he was referred to START (Harlem 2), but SW neither gave him a referral form, nor is there any indication that SW attempted to contact the program to confirm that they would accept the referral.

The delayed CTP was associated with him not being produced on May 13 and May 23 as well as his refusal on May 27. On May 27 he was transferred to MO housing for suicide watch where he stayed until June 7, when his suicide watch was removed. However, the suicide watch was reinitiated almost immediately. On June 14 a court collateral note documented a parole hearing scheduled for July 16 and that the administrative law judge had indicated a plan for revoke and restore with placement in an inpatient program. The ACL of July 16, the day of his release, indicates that the class member was to report to a residential program on July 19 at 9:00AM. He was provided with a referral form and ACL, which noted this appointment.

Findings:
Referral/appointment: inappropriate (referral not provided to class member, no contact) → appropriate (ATI)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 17, July MO187, was a 37 year old man who was incarcerated from May 9 to July 4 connected at least in part with a parole violation. The initial medical screening of May 19 noted the class member's history of a diagnosis of schizophrenia, a state hospital admission in 2019, leading to "stat" referral to mental health staff for evaluation. The class member was scheduled for an initial psychiatric assessment on May 14, but refused "from the housing area." His medications were "bridged" on May 16. On May 20, ten days after the referral, he was seen for an initial assessment. The resulting note indicated that he "was referred by medical to psych after CDU clearance from COVID." This may have played in part in the delayed assessment. The class member was transferred from West Facility to C71 on May 24.

He was housed in MO at the time of his CTP, where he was diagnosed with schizophrenia; he was considered SMI and was noted to be receiving SSI. His CTP, on May 28, was 1 day late, and noted that he had been residing in supportive housing, where he was receiving treatment including PROS. His DCP, on June 8, was timely. He was referred to TSI, his prior provider, and was given a referral form. SW contacted TSI to confirm that he could return. He was also referred to CRAN. SW confirmed that he was in supportive housing. They discussed this with CRAN, and they agreed that a new application need not be submitted.

The prescriber obtained useful collateral information regarding the class member's medications and noted that she spoke with his case worker. On June 4, the class member informed mental health staff that he would be amenable to returning to supportive housing. His criminal case was transferred to mental health court on June 17. The ACL reiterated a referral to TSI but did not address his housing needs. The class member was reincarcerated on July 12 per the CRAN record.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: appropriate

Case 20, July MO202, was a 32 year old man who was incarcerated from June 7 to July 24. He was housed in MO at the time of his timely CTP on June 14, where he was diagnosed with schizoaffective disorder and SUDs; he was considered SMI. At his timely DCP, on June 17, he was referred to CSEDNY and CRAN. A housing application was submitted on June 23, but neither the application nor HRA's response appear in the record.

Although he was referred to CRAN, he refused to meet with them on two occasions and his case was closed on July 20. The 30-day follow up of July 22 noted the CRAN refusal and prior referrals to CSEDNY. It also noted prior submission of an HRA 2010e, however there was no indication that SW followed up regarding the absence of a response from HRA. No changes were

made to the DCP. The psychiatrist saw the class member on July 24, the day of release, clearing him for discharge and noting the referral to CSEDNY.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: inappropriate (SW never followed up regarding the absence of a response from HRA)

Case 21, July GPMEDS6, was a 31 year old transgender man who was incarcerated on a parole violation from July 27, 2020 to July 29, 2021. After his initial mental health assessment on July 29, he was transferred to MO on suicide watch later that day but returned to GP on July 31, 2020. He was housed in GP at the time of his timely CTP on August 6, where he was diagnosed with other specified trauma and stressor disorder, borderline personality disorder, and substance use disorders; he was not considered SMI. The CTP did not review his functional status in the context of his diagnosis of borderline personality disorder and his being housed at a transitional living residence at Kingsboro prior to incarceration.

A DCP, was attempted on August 19, 2 days late, but was noted to be "pending" because he was "aggressive." The DCP was completed without his involvement and did not provide any discharge planning services. SW noted that he was previously in the transitional living residence (TLR) at Kingsboro. He was also followed by the Kingsboro Mobile Integration Team, which SW attempted to contact.

Upon admission to Kingsboro on May 22, 2020, he was diagnosed with schizoaffective disorder and substance use disorder.

On September 9, 2020 he refused a SW visit. By September 11, 2020 he was sent to the Elmhurst Hospital emergency room where he remained in the CPEP until September 15, 2020. He was then transferred to Kirby Psychiatric Center where he stayed until September 22, 2020. The Kirby discharge summary indicated a diagnosis of schizoaffective disorder. Following his return to jail none of the TPRs adopted a psychotic or mood diagnosis.

The SW 30-day follow up of October 7, 2020, indicated contact with his attorney. The 30-day SW follow up of November 25, 2020 noted that his attorney was attempting to refer him to CRAN. On December 1, 2020, SW followed up with CRAN regarding their role for a possible ATI but "CRAN clarified that they only work with SMI Yes clients." SW confirmed the CM's diagnosis and his SMI no status. On December 10, 2020, SW documented that the CM's parole attorney may be referring him to SCJP and also noted that the CM was "…tracked by OMH [sustained engagement support] team… [and that he was] unable to access OMH residential services at this time." SW submitted a referral to WCJP on December 13, 2020. On December 23, 2020 SW learned from the attorney that he was being referred to TASC for an ATI. SW then emailed TASC to confirm. Later, the CM indicated that he was a transgender man and had begun taking testosterone early in 2021.

The CM was again sent to the emergency room on February 12 after another overdose on pills and was admitted to EHPW from February 13 to February 16. At EHPW an unexpected release form was created on February 16, which directed the CM to a referral to BronxCare adult outpatient clinic. SW faxed the form to CHS SW. According to the hospital record, an

appointment was needed at BronxCare, and as an alternative they indicated he should present to Bellevue Hospital for aftercare treatment. Following his return to jail, there was a 30-day follow up note of February 16 where TASC, Greenhope and WCJP were discussed as potential referrals. Another 30-day follow-up of February 17 indicated that the CM said he was found eligible for inpatient placements. The SW contacted TASC who indicated that he was scheduled for an interview for Samaritan Village on February 23, with his next court date on February 25. On February 23, SW assisted the CM to engage in a telephone screening with Samaritan Village.

A subsequent clinical note on March 10 included a very good description of the CM's serious dysfunction related to his character pathology. On March 23, the SW noted TASC's continued involvement in the CM's case with a new court date of March 31. On April 22 staff informed the CM that he was "was not accepted into any of the programs due to his aggressive behavior… agreed that he will benefit from ongoing community-based treatment." A 90-day SW follow up note of May 12 noted that he was waiting for a resolution of his criminal case before his parole hold could be resolved. There was no change to his DCP.

On July 9, SW spoke with the CM about HomeBase program and initiated an inquiry for this program via email. SW also noted that the CM did not "want to go to a shelter and if he can go to Brooklyn TLR, he is open to that option…. SW will follow up with him once more information regarding TLR becomes available." On July 13, SW met with the CM to obtain consent for submission of HRA 2010e and SPOA referrals, which he was agreeable to. SPOA determined him to be eligible as of July 19 but could not assign a case management team because of his continued incarceration. Staff maintained his designation of SMI-No. SW participated in an OMH SES case conference concerning the CM on July 21. On July 23, mental health staff documented his likely upcoming release, and that the CM was aware that a civil discharge was in place. He stated the belief that he would be returning to parole in New York City. They discussed shelter options for housing as well as the possibility of treatment at Callen Lorde. On July 25, mental health documented a possible hotel placement for the CM. The following day he expressed his frustration that mental health and SW were "… not helping him." SW saw the CM on July 27 and the director of SW reviewed the plan for civil discharge to Elmhurst Hospital CPEP with a plan for him to transfer to Creedmoor for longer treatment, that ACT was pending, and that he had been referred to Callen Lorde. The CTP was updated on July 28, with no mention of a change of SMI status. On August 3, four days after release, he was assigned to SUS ACT. The hospital record indicated that the CM was transferred to Creedmoor after an overnight stay in the in the emergency room. Upon discharge from the hospital his diagnosis was schizoaffective disorder.

Despite a circuitous route and staffs' insufficient attention to this CM's high degree of functional impairment especially during the time when he was not considered to be SMI, the ultimate referral to Creedmoor was appropriate for this CM. The SMI rating was inappropriate with little effort to hone the diagnosis or be attentive to the clear and extreme dysfunction he presented. The ultimate connection with ACT was appropriate and also supported him being SMI. Supportive housing would have been inappropriate flowing from the incorrect SMI no rating, but he was likely to remain in OMH housing.

Findings:
Referral/appointment: appropriate
SMI: inappropriate (There was no consideration given to the clear and extreme dysfunction resulting from his psychiatric diagnosis)
Case Management: appropriate (Despite his mischaracterization as not SMI, he was ultimately accepted to ACT which may be useful as he transitions from Creedmoor inpatient to a lower level of care)
Supportive Housing: ineligible (Would have been inappropriate b/c the SW never submitted the application, but he is likely to remain in OMH housing after hospital discharge)
Focus for Remediation: A case conference (or a series of case conferences) would likely have resulted in a more appropriate SMI assessment.

Case 22, July MO51, was a 38 year old man who was incarcerated from February 22 to July 9, 2021. He was not produced for his initial mental health assessment on March 5. The record documents that on March 8 DOC reported that he refused to come from his housing to complete this assessment. His first contact with mental health occurred on March 10 when he was seen for the initial assessment with a disposition of GP no follow up; he was seen again on March 21 with the same outcome. On May 14, he was not produced for a visit but was seen later that day in his housing unit when the class member indicated that he needed to meet with mental health. At this point, he became a class member, and, as he was housed in GP, staff had 15 days to complete the CTP. He was not produced on May 16 because no DOC was available, he was not produced on May 20 for no documented reason, he was not produced on May 24 because he had been "sent out" due to a "medical emergency," and he was again not produced on May 25 for no documented reason. He was eventually seen by mental health on May 26, at which point he was assessed as requiring C71 level care, resetting the deadline for completion of the CTP to June 2. At his timely CTP on June 1, he was diagnosed with delusional disorder and SUDs; he was considered SMI.

DCP attempted to see the class member on June 14 (four days late) but could not do so because of "safety concerns on the unit." He was a civil discharge on July 9. SW saw him at this time, and he accepted referrals to Metropolitan outpatient clinic (which has walk in intakes) and CRAN. SW communicated with CRAN to inform them of his discharge to Elmhurst Hospital for evaluation for possible civil commitment. Despite the multiple disruptions, SW eventually saw the class member, provided appropriate referrals, and appropriately communicated with CRAN in an effort to minimize disruption to the aftercare plans which could be caused by civil discharge.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: ineligible

Case 23, July MO71, was a 42 year old man who was incarcerated from February 2 to July 22, 2021. He was housed in MO at the time of his timely CTP on February 10, where he was diagnosed with schizophrenia and substance use disorders; he was considered SMI. The CTP

also noted "cognitive limitations and possible intellectual disability." At his timely DCP on February 12, he was given a referral form for the Nathaniel clinic, who was contacted to confirm that they would accept the referral. He was also referred to CRAN and to care coordination. SW determined that he was not eligible for referrals to SPOA or AOT due to lack of hospitalizations; they made no effort to obtain historical information from outside of New York.

During a TPR of March 1, he reported a plan to return to Maryland following his release. A note of March 10 reported his interview with Fortune Society, and the 30-day follow up note of March 24 indicated that he was still waiting for a response. As of March 29, Fortune Society was still reviewing his application, but a 30-day follow up note of May 10 indicated that, as per mental health court, he was found eligible for Fortune Society and was awaiting a bed. He was also to be screened at Harbor House on May 17, which, via a letter of June 22, also accepted the class member.

A court collateral note from June 24 indicated an expected release date of July 22, with the possibility advancing his release should a bed become available sooner. By July 9 the plan was for him to present to court on July 22, enter a plea, and be released to Harbor House. The referral to Harbor House was reinforced by the ACL of July 19. On July 27, five days after his scheduled release, Harbor House contacted CHS requesting COVID vaccine dates suggesting that he had successfully connected with the program.

Findings:

Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case Management: appropriate → ineligible (ATI)
Supportive Housing: appropriate → ineligible (residential ATI)

Case 24, July MO206, was a 47 year old man who was incarcerated from June 10 to July 20. He was housed in MO at the time of his CTP on June 25, five days late, where he was diagnosed with schizophrenia; he was not initially considered SMI, but that designation was changed to "SMI: yes" 3 days later. At his timely DCP on June 29, he refused a referral, indicating that he would return to Metropolitan on his own. He accepted referrals to CRAN and to SPOA for IMT, but the SPOA application was incomplete, lacking a psychiatric evaluation, housing status, and information regarding recent and frequent contact with the mental health system. He refused a supportive housing application, indicating he had a prior SRO, but SW noted that placement to be "in jeopardy." SW did not attempt to contact the SRO to ascertain whether he could return. The deficiencies in the SPOA application were remedied, and he was assigned to care coordination and placed on a waitlist for ACT on July 28.

Findings:

Referral/appointment: ineligible
SMI: appropriate
Case Management: appropriate
Supportive Housing: inappropriate (Did not make any attempt to contact SRO to confirm he could return)

Case 25, August GPMEDS6, was a 32 year old man who was incarcerated from March 13 to August 23, 2021. He was housed in GP at the time of his timely CTP on April 5, where he was

diagnosed with adjustment disorder and substance use disorders; he was not considered SMI. On April 14, a DCP form was completed by chart review on April 14 because he refused "from the housing area." At his DCP on May 11, which was 27 days late, he was given a referral form to Damian Family Health Center, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Findings:

Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 26, August GPMEDS23, was a 29 year old man who was incarcerated from March 5 to August 6, 2021. He was housed in GP at the time of his CTP on April 15, 23 days late, where he was diagnosed with adjustment disorder and substance use disorders; he was not considered SMI. The class member's CTP noted a prior history of antisocial personality disorder as well as other specified conduct and dysthymic disorders. The CTP also noted that he was approved for supportive housing just prior to incarceration.

At his DCP on May 6, which was 10 days late, he was given a referral form to the Nathaniel clinic, but there is no indication that the social worker attempted to contact the program to confirm that they would accept the referral. The social worker confirmed that the class member had previously been approved for supportive housing based on an application done in a shelter but did not follow up to confirm and obtain this approval or forward it to housing providers.

The ACL of August 6 noted that his prescriptions were sent to a pharmacy in Brooklyn, even though the class member was going to reside in the Bellevue Shelter and would be receiving treatment with the Nathaniel clinic CASES, both of which are in Manhattan.

> ***CHS Response****: CHS disagrees with the rating of Case 26 as inappropriate for supportive housing. The determination should be changed to "appropriate" because Social Work did not have to contact the housing provider as they were operating under an SMI-NO diagnosis.*
>
> **Monitors' Response**: Where a class member has previously been approved for supportive housing, it is inappropriate not to follow through on that prior approval regardless of the class member's current SMI designation.

Findings:

Referral/appointment: inappropriate (pharmacy not convenient)
SMI: appropriate
Case Management: ineligible
Supportive Housing: inappropriate (No effort to follow up on the prior approval)

Case 27, August GPMEDS40, was a 44 year old man who was incarcerated from November 19, 2019 to August 25, 2021. He was housed in GP at the time of his CTP on January 21, 2020, which was 6 days late. He was diagnosed with other specified trauma and stressor disorder, and substance use disorders; he was not considered SMI. At his timely DCP on January 30, 2020, he

was referred to Acacia Network, his prior provider. SW contacted his prior therapist who indicated that he could return. He was given a referral form.

A 90-day follow up by SW, on August 17, 2020, reiterated the CM's willingness to follow up at Acacia Network outpatient treatment but also noted that he was hoping to receive an inpatient program. SW saw him on October 8, 2020 in response to a referral from mental health indicating that he was trying to contact his attorney. He requested assistance in contacting his attorney and ascertaining his next court date and to find out more information about his case. SW indicated they would follow up on these requests. A 90-day follow up by SW, on November 22, 2020, did not result in any update to his DCP. SW saw the CM on January 11 regarding possible contact with his attorney. The following day, the attorney spoke with SW concerning a potential ATI and the attorney requested the CM's medical records. SW forwarded the request to the medical records department.

A TPR of March 5 indicated that the CM was interviewed for a possible program. At a 90-day follow up on May 13, SW noted that the attorney confirmed the ATI offer and indicated that the CM should be getting released on or about his next court day of June 24. However, at a 90-day follow up on August 18, SW documented that he was still waiting for an ATI; the SW reached out to the attorney. Collateral information obtained by the same SW the following day indicated he was going to be released to CREATE, a residential mental health and substance use disorder program run by Argus community. A DCP update of August 23 reiterated this information. An ACL of the same day documented this same information, indicating that he would be transported to this placement by the sheriff.

Findings:

Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 28, August GPMEDS61, was a 42 year old man who was incarcerated from September 19, 2020 to August 3, 2021. He was housed in GP at the time of his timely CTP on November 6, 2020, where he was diagnosed with other specified schizophrenia; he was considered SMI. At his timely DCP on November 10, 2020, he was given a referral form for Samaritan Village, but there is no indication that the social worker attempted to contact the program to confirm that they would accept the referral. He also was referred to CRAN, SPOA and AOT, and he accepted a supportive housing application. The housing application was approved on November 18, 2020 and was forwarded to CRAN and two providers.

Thirty-day follow ups by SW on January 7, March 1, and March 24 indicated no updates to the DCP. A SW note of July 22 indicates that he already had a Manhattan Justice Community Case Manager, that he was eligible for an ATI, and that he was to enter residential treatment at Argus community. The ACL of August 2, which was provided to the class member, showed that he was to go to Stiver House/Argus for residential placement as part of an ATI.

Findings:
Referral/appointment: inappropriate (no contact) → appropriate (ATI)
SMI: appropriate
Case Management: appropriate → ineligible (ATI)
Supportive Housing: appropriate → ineligible (residential ATI)

Case 29, August GPMEDS85, was a 57 year old man who was incarcerated on a parole violation from July 1 to August 25. He was housed in GP at the time of his timely CTP on July 15, where he was diagnosed with schizoaffective disorder; he was considered SMI. At his timely DCP on July 22, he was given a referral form to the Kingsboro Williamsburg outpatient clinic, and the SW contacted the program to confirm that they would accept the referral. He was also referred to CRAN, but as he was not homeless, no 2010e was offered.

The class member was transferred to the hospital for medical treatment on August 11, where he stayed for the remainder of his incarceration. After release from custody, he was transferred to a civilian inpatient psychiatric unit where, according to the CRAN record, he remained for several weeks.

There was some confusion surrounding this CM's Medicaid status. The July 4 prescreen found active coverage. According to HRA he was released on August 26 with Medicaid status "WMS EXT," but his Medicaid was closed on August 31. We determined that in this instance, given his hospitalization and his referral to an OMH affiliated outpatient provider, this would not likely have interrupted his receipt of treatment, and we retained the rating appropriate for appointment/referral.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: ineligible

Case 31, August GPNOMEDS105, was a 32 year old man who was incarcerated from December 9, 2020 to August 6, 2021. He was housed in GP at the time of his timely CTP on December 31, 2020, where he was diagnosed with other specified trauma and stressor disorder; he was not considered SMI. At his timely DCP on January 11, he was given a referral form to Gotham Morrisania, but the program was not contacted to ascertain its capacity and willingness to accept the referral. The referral was reiterated in an ACL near the date of release.

Findings:
Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 32, August MO10, was a 51 year old man who was incarcerated from May 7 to August 10. He was housed in MO at the time of his timely CTP on May 13, where he was diagnosed with schizophrenia; he was considered SMI. At his timely DCP on May 18, he was given a referral form to Metropolitan, who was contacted to confirm that they would accept the referral. He was also referred to CRAN, but he was not referred to SPOA or AOT due to a lack of inpatient

admissions. He accepted a supportive housing application which was approved on May 25 and sent to two providers and to CRAN.

The CM was unexpectedly released from court on August 10. CRAN documents that he was residing with his sister on the day after release. On August 12, he presented to CRAN requesting assistance with housing, entitlements and retrieving his property. CRAN also assisted him in confirming a walk in appointment for treatment at Metropolitan Hospital and in getting his medications through a PORT clinic. The CM also inquired about the status of his HRA 2010e application. For unknown reasons, CRAN did not follow up on his 2010e application until September 1.

According to the prescreen on May 12, the class member's Medicaid was active. According to the HRA data set, his Medicaid status was WMS-EXT, signifying continuing coverage. The CRAN record indicated that his Medicaid was closed on July 23, however by September 14 it was again active.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: appropriate

Case 33, August MO42, was a 32 year old man who was incarcerated from March 20 to August 26. He was transferred to BHPW on March 24 and remained there during the rest of his incarceration. At his timely CTP on March 25, where he was diagnosed with schizophrenia; no SMI determination was made. No DCP was completed. BHPW staff prepared an unexpected release form on March 25, the day after his admission, noting that he was "too unpredictable" to sign it.

The CM stabilized after a considerable amount of time, but the hospital did not discharge him to jail. Because he refused COVID testing, he would have had to go directly to the CDU for quarantine and his treating providers were concerned that he would decompensate if not admitted directly to the PACE unit. Instead, the hospital kept him on the BHPW and collaborated with this attorney and the court to develop an ATI.

SW began to work with the CM on June 29, raising the possibility of SPOA and AOT. His attorney reported that an ATI was a possibility. On July 6, the CM agreed to a SPOA application and the initiation of AOT. By July 20, SW documented that an ATI was in progress and that he was being evaluated by CASES which was also exploring the possibility of housing at Fortune Society. By August 17, the details of the ATI were in place; SW documented that he would be housed at Fortune Society with treatment at CASES ACT, where he was assigned a slot by SPOA. The AOT referral had been submitted and his Medicaid status was to be clarified by FHCI. No HRA 2010e was required because of the planned housing at Fortune Society. A SW note from August 24 indicated that, although his treatment at CASES ACT was in place, Fortune Society had not yet responded regarding his housing. The note also stated that he did not sign the unexpected release form "…give[n] that he has opted to engage in a more personalized discharge plan." In fact, the record previously noted that the reason he did not sign the form was that he was considered too unpredictable. This, more "personalized" plan was appropriate for this CM's

needs, but this raises the question of why BHPW staff would not engage in more individualized discharge planning for more CMs hospitalized on their unit.

The discharge summary noted that he was to be held in the civil unit until the Fortune Society housing slot was available because of the risk for decompensation if undomiciled. In contrast, a SW note of August 27 documented that the CM was accepted to Exodus hotel placement and would be going there.

Findings:

Referral/appointment: appropriate (ATI)
SMI: appropriate (while there is no affirmative statement as to his SMI status, staff provided him with appropriate services consistent with an SMI-yes determination)
Case Management: appropriate (ATI)
Supportive Housing: ineligible (ATI)

Case 34, August MO43, was a 37 year old man who was incarcerated from December 15, 2020 to August 12, 2021. He was housed in MO at the time of his timely CTP on December 18, 2020, where he was diagnosed with schizophrenia and SUDs; he was considered SMI. The clinician also documented a possible cognitive disorder and recommended further assessment of this issue.

At his timely DCP on December 29, 2020, he was referred to CASES Nathaniel clinic, but SW did not give him a referral form, nor did they attempt to contact the program to confirm that they would accept the referral. He was also referred to CRAN, to SPOA for FACT, and to AOT. Finally, he accepted a supportive housing application which was approved on January 6 and forward it to CRAN. SPOA and two housing providers.

The SW 30-day follow up on January 28 documented that, during a previous incarceration, the CM was released to Harbor House on an ATI but that he left before completing treatment. Despite this, the Brooklyn Mental Health Court agreed to pursue another ATI disposition for the instant incarceration, and SW agreed to assist in this pursuit. A 30-day follow up on March 3 indicated that Harbor House did not agree to the CM's return and that the court was exploring other possible programs. Fortune Society conducted a telephone screening on March 23. A 30-day follow up on April 8 noted that the CM was held on a parole violation and that he was awaiting a response from Fortune Society. With a well-documented rationale, mental health staff changed the diagnosis on April 21 to borderline personality disorder, substance induced personality disorder with substance use disorders, and retained the SMI yes designation.

On May 6, SW documented the CM's acceptance by Fortune Society and that he was awaiting a bed. On June 8, SW noted that that he was still waiting for a bed and that the court had also referred him to Camelot. A 30-day follow up on July 8 noted that he continued to wait for a bed. An ACL on August 8 documented that he was being released to an ATI at Freedom House, a program run by Fortune Society.

Findings:

Referral/appointment: inappropriate (referral not provided to class member, no contact) → appropriate (ATI)
SMI: appropriate
Case Management: appropriate → ineligible (ATI)
Supportive Housing: appropriate → ineligible (residential ATI)

Case 35, August MO68, was a 22 year old man who was incarcerated from August 18, 2020 to August 23, 2021. He was housed in MO at the time of his timely CTP on August 26, 2020, where he was diagnosed with other specified trauma and stressor disorder, K2 induced psychosis, and SUDs; he was not considered SMI. This CM returned from a ten-week stay at Mid-Hudson Psychiatric Center with a diagnosis of schizophrenia. Upon return to jail, his diagnosis was changed to other specified trauma and stressor disorder and drug related disorders, with the rationale that his bizarre behaviors were "better explained by K2 use."

At his timely DCP on August 31, 2020, he refused a mental health referral.

A prescriber's note of October 5, 2020 found him to be asymptomatic after weeks of not taking his medications. His risperidone was discontinued, and he was transferred to GP. By November 18, 2020, he appeared somewhat more psychotic; he was described as smiling to himself and being confused, stating that he was raped and then that he was not. A diagnosis of rule out other specified schizophrenia was added. The same day, he was transferred to the emergency room after taking 16 pills, possibly melatonin. On November 20, 2020, he informed his attorney that he wished to resume taking medications. He was transferred to C71 on November 25, 2021, after demonstrating a disturbed mental status; he was seen by psychiatry and restarted on risperidone.

A 90-day SW follow up note of November 29, 2020 documented that the SW observed the CM masturbating in his cell and confirmed that he was undomiciled, as he had been residing in a shelter in Sunset Park. No changes to the DCP were made. On December 14, 2020, his psychiatric appointment was administratively cancelled by CHS. A bridge order for his medications was made, with a note from the prescriber that compliance information was unavailable. He saw the psychiatrist on December 11, 2020, when he was noted to be taking all of his prescribed medication. His mental status exam was normal, and no changes were made to his diagnosis. At a TPR of December 14, 2020, he was found to be detached and oddly related but still more engaged than previously. No changes were made to his diagnosis at that time. Court collateral was contacted by the SW from Brooklyn Defenders on December 15, 2020, at which time she expressed concern over the CM's RHU placement and possibility that it was contributing to his decompensation. She requested immediate transfer to a mental health unit. The CM was again transferred to C71 on December 16, 2020. At that time, he appeared decompensated in the context of poor adherence to medications, which were discontinued during this appointment. He was seen later the same day when he threatened the prescriber; his medications were restarted although he stated he did not want them. There was no change to his diagnosis.

The TPR of December 17, 2020 contained an excellent review of the CM's clinical history with an assessment that reinforces a psychotic disorder diagnosis. He was re-diagnosed with schizophrenia along with other specified trauma and stressor disorder and his SMI status was changed to yes.

On January 19 SW attempted to engage with the CM but he refused. Another DCP was completed on January 29, which referred him to Nathaniel clinic, CRAN, and SPOA. He accepted an HRA 2010e at that time. Although Nathaniel was not contacted to ascertain their capacity and willingness to accept the referral, the referral form noted specific walk in hours. The 30-day follow up on March 15 did not result in any changes to the DCP. On April 5, SW assisted the CM in calling the case worker associated with his attorney so they could reconnect.

On April 14, he was cleared from CAPS and apparently was transferred to VCBC. By April 18, he was again highly symptomatic and returned to C71. On April 19, C71 discharged him to GP while noting that his medication adherence was at 17 percent. The next day, he was seen as highly disorganized, and he was transferred back to MO on suicide watch.

After a long and unexplained delay, SW submitted the HRA 2010e on June 24. Also on this date, a SPOA referral for ACT was competed, and an AOT referral was completed. The CM was approved for supportive housing on July 1, and on July 15, SW forwarded the approval to CRAN, AOT and three housing providers.

The CM was hospitalized at BHPW from July 2 to July 8, where he was diagnosed as not psychotic with an adjustment disorder and antisocial personality disorder. However, upon return to jail on July 15, the prescriber noted his overall history and diagnosed him with schizophrenia with an SMI yes designation.

The 30-day follow up on July 26 noted his refusal to engage and that he was not on medication. No changes to the DCP were made.

On August 19, the CM was found hanging in his cell and was sent to the hospital via EMS. He remained hospitalized after he was released from custody on August 26. Per a note dated September 3, he was released from incarceration and admitted to Elmhurst inpatient psychiatry. He was given an appointment at Nathaniel clinic for September 8 at 3pm. SW informed the SW at Elmhurst of the DCP including the appointment at Nathaniel, as well as the SPOA and AOT referrals, and the HRA 2010e approval. One aspect of the overall excellent coordination between jail SW and the hospital regarding discharge planning issues is the fact that CHS and Elmhurst were in contact regarding the SPOA placement. The CRAN record indicated that, on September 1, CRAN was also in communication with the hospital to coordinate aftercare.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: appropriate

Case 36, August MO90, was an 18 year old man who was incarcerated from June 22, 2020 to August 19, 2021. He was housed at BHPW at the time of his timely CTP on June 22, 2020, where he was diagnosed with schizophreniform disorder; he was considered SMI. He refused to sign an unexpected release form on June 22, 2020.

Following the class member's return to jail on July 9, his DCP was completed on July 23, 2020 (24 days late) at which point he was referred to Fortune Society. He was interviewed by the Fortune Society court advocate, but he was not given a referral form regarding this referral. He agreed to a SPOA application for ACT, but this was never completed. He also agreed to assistance with an HRA 2020e for supportive housing. SW submitted the HRA 2010e application on August 14, 2020. The record indicates neither a response from HRA, nor any effort by SW to determine what the result of the application was.

Jail staff initially accepted the diagnosis of schizophreniform and considered him SMI, but at the CTP on July 17, 2020, staff commented that he more likely met the temporal criteria for schizophrenia. On September 17, 2020, the prescriber recharacterized his diagnosis as trauma based, changing it to other specified trauma and stressor disorder and rule out schizophrenia. The

prescriber continued him on aripiprazole 30 mg. However, no other clinician adopted these changes, and instead continued using a diagnosis of schizophrenia throughout subsequent progress notes and in TPRs.

The 30-day follow up of October 18, 2020 made no changes to the DCP. By January 19, 2021 the prescriber had "ruled out" a primary psychotic disorder, re-diagnosing the CM with other specified trauma and stressor disorder and adjustment disorder. Antipsychotic medications were continued, in addition to sertraline and prazosin. However, the TPR of January 23 retained the diagnosis of schizophrenia. Subsequently, the diagnostic split between the clinicians and prescriber continued through the next two months.

On March 3 the prescriber noted the CM's adherence to his prescribed medications, although a note of March 16 reported that he had been "cheeking" his medications. The prescriber discontinued all medications on March 16 because of the CM's non-compliance, adverse effects, and the assessment that they were not "beneficial." Further, the prescriber noted that the CM remained in good behavioral control and reported no worsening of symptoms. The following day, a MH clinician documented that the CM remained SMI yes but that his diagnosis had been changed to other specified trauma and stressor disorder and adjustment disorder, psychotic spectrum disorder was ruled out, and schizophrenia was removed from the diagnosis. Subsequent clinicians adopted the other specified trauma and stressor disorder and adjustment disorder diagnoses, and retained the SMI Yes designation.

The next SW contact occurred on June 10, animated by the CM's request to speak with SW. No specific discharge planning content was documented. On July 5, the CM informed mental health that he was anxious because of an upcoming court date, when he would find out about residential placement. SW coordinated a teleconference on August 13 with staff from a residential school, but it remained unclear whether he received an ATI. SW did assist with an interview but there is no documentation where he was ultimately placed or how it was arranged. As a result, the ratings of this case were based on the July 23, 2020, DCP completed at AMKC, discussed above, which was inappropriate for appointment referral because the referral form was not provided to the CM, inappropriate for case management because the SPOA application was not submitted, and inappropriate for supportive housing because HRA did not respond to the application and SW did not follow up on the lack of response.

Findings:

Referral/appointment: inappropriate (referral not provided to class member)
SMI: appropriate
Case Management: inappropriate (SPOA application not submitted)
Supportive Housing: inappropriate (no response from HRA or inquiry by SW)

Case 37, August MO94, was a 36 year old man who was incarcerated from June 24 to August 18, 2021. Upon intake on June 26, medical made a stat referral to mental health following his report of feelings of worthlessness, hopelessness, and suicidal ideation. On July 9, his attorney on his criminal case contacted CHS voicing concerns about the class member's mental status. He was not produced for an initial assessment attempted on July 11, July 15, July 21, or July 22. He was seen July 26 following this transfer from OBCC to VCBC. Based on his reported symptoms of depressive and trauma-related disorders, and his reported history of numerous inpatient

admissions, he was given a diagnosis of other specified trauma and stressor disorder and various substance use disorders. He was transferred to C71 on suicide watch.

He was housed in MO at the time of his timely CTP on July 30, where he was diagnosed with other specified trauma and stressor disorder, and substance use disorders; he was not considered SMI. While there is some evidence for low functioning, substance use appeared to play a considerable role in his dysfunction.

At his timely DCP on August 3, he was given a referral form to Realization, but there is no indication that the social worker attempted to contact the program to confirm that they would accept the referral.

Findings:

Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 38, August MO108, was a 56 year old, undomiciled, man who was incarcerated on a parole violation from May 25 to August 13, 2021 after being stabilized at Kirby. He was housed in MO at the time of his timely CTP on May 28, where he was diagnosed with other specified schizophrenia and SUDs; he was considered SMI. At his timely DCP on May 31, he was referred to the Bellevue ACT program and to CRAN. He was noted to have an active AOT investigation in progress. He also was noted to have an active 2010e approval good through January 24, 2022.

A 30-day follow up on July 13 resulted in no updates to the DCP but indicated that the SW was planning on talking with his attorney. On August 2, SW noted that the CM had been discharged from his ACT, but that the program would be willing to reaccept him pursuant to a new SPOA referral. However, a SPOA referral was not submitted. He was not referred to CRAN. An ACL on August 13, which SW gave to the CM, referred him to CASES Nathaniel clinic and back to his previous ACT program. There is no indication that SW attempted to contact Nathaniel clinic to determine if they would accept the referral. The involvement of an AOT monitor was also noted. Although he had a prior HRA 2010e approval, SW did not obtain it or forward it to providers. A SW note on August 13 indicated that a civil discharge was in place and that the SW would notify the CPEP at Elmhurst Hospital of his DCP. On August 26, the 730 mobile team documented the CM's unexpected release on August 13, and noted that he had been referred to his ACT program.

This highly impaired, SMI, sentenced[1] CM was listed as "not in timeframe" in the SSI new application dataset. Although he reported no SSI history at the time of admission, his 80-day incarceration provided adequate time for SW to offer assistance with an application, which SW should have done. While not impacting a specific rating, the failure to offer an SSI application to this SMI class member was a significant DCP oversight.

***CHS Response**: CHS disagrees with the rating of Case 38 as inappropriate for referral/appointment, case management, and supportive housing. All three determinations should be changed to "appropriate" because the patient was mandated to Phoenix House as*

[1] IIS includes a projected release data of August 14 (a Saturday).

a condition of her release. Social Work correctly noted that the patient would not complete an ACT referral to re-open an ACT case because the patient was going into an ATI program.

Monitors' Response: There is no indication in the record provided that the class member was given an ATI or sent to Phoenix House. The ACL explicitly states that he did not have an ATI placement.

Findings:
Referral/appointment: inappropriate (no contact with Nathaniel clinic, prior ACT case was closed, no new SPOA application was submitted to reactivate his ACT eligibility)
SMI: appropriate
Case Management: inappropriate (no CRAN or SPOA referrals were done)
Supportive Housing: inappropriate (did not obtain or act on the prior 2010e approval)

Case 39, August MO112, was a 64 year old man who was incarcerated on a parole violation from January 21 to August 13, 2021. He was housed in MO at the time of his timely CTP on January 29, where he was diagnosed with adjustment disorder and alcohol use disorder; he was not considered SMI. The CTP noted that he would "max out" on parole in seven months and referred him to SW. At his timely DCP on February 5, he was given a referral form for the PAC program. SW contacted the program, who confirmed that he could obtain treatment at this program as long as he had Medicaid. According to HRA, his Medicaid was suspended at the time of release, and it was reactivated on August 16, the first business day after he was released.
Findings:
Referral/appointment: appropriate
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 40, August MO123, was a 54 year old man who was incarcerated from March 3 to August 17. This class member, whose intake noted a prior treatment history with the Veteran's Administration (VA), was not produced for his CTP on March 21. He was housed in GP as late as March 8 but transferred to AMKC on March 18. It was unclear if he was initially housed in the MO at AMKC, but by March 22 he was seen, and a psychiatrist ordered him to C71 on March 23. He was housed in MO at the time of his CTP, which was 9 days late on March 30, and he was diagnosed with bipolar 1, other specified trauma and stressor disorder, and cocaine use disorder; he was considered SMI.

At his DCP on April 8, which was completed without his participation, he was referred to the Manhattan VA. He was not given a referral form. There are numerous notes in the record indicating communication with the VA as to his treatment and case management. He was referred back to his VA-based case management/ACT program. He indicated he could return to his NYCHA apartment.

On April 28, he declined further assistance from SW because he was waiting to speak with his attorney. SW conducted a single 30-day follow up on July 13, which did not result in an updated DCP.

Findings:
Referral/appointment: inappropriate (CM did not participate in DCP and was not provided with a referral form)
SMI: appropriate
Case Management: appropriate
Supportive Housing: ineligible

Case 41, August MO127, was a 39 year old man who was incarcerated from March 11 to August 4. He was housed in MO at the time of his timely CTP on June 17, where he was diagnosed with adjustment disorder and substance use disorders; he was not considered SMI. At his timely DCP on June 22 he was given a referral form to Samaritan Village outpatient clinic. Social work contacted the program to confirm that they would accept the referral. He was not homeless.

The CM's CTP noted that he had "impairment multiple areas of function such as legal, academic, vocational, housing, substance use, interpersonal relationships," but assessed him as being SMI no. On June 18, a clinical supervisor added the diagnosis of other specified trauma and stressor disorder based a review of the CM's history. The psychiatrist treated the CM with risperidone. On June 24, noting "…PTSD intrusive thoughts and auditory hallucinations," the psychiatrist increased the dose of risperidone and added fluoxetine and prazosin. Collateral information obtained from his mother suggested more severe and longstanding illness than that initially assessed by mental health staff.

None of the assessments attempted to explain why he was not considered SMI in light of the numerous areas of dysfunction noted, especially in light of the prescriber's increase of his medication and concern about PTSD symptoms.

***CHS Response**: CHS disagrees with the rating of Case 41 as inappropriate for SMI diagnosis. We disagree that there was inadequate consideration of the patient's psychiatric history and presenting symptoms when determining his diagnosis and SMI designation. The patient was assessed by mental health on two occasions shortly after his admission whereupon he denied and did not present with psychiatric symptoms, and declined services. He was able to function in general population without significant difficulties for three months, until he was referred to mental health due to a pending 730 evaluation. Noted in his psych basic and CTP were that the patient had been smoking K2 during his incarceration (and on the day prior to his psych basic), and that he had been using crystal meth for two years prior his incarceration. Even with the caveat of substance use, the psychiatric prescriber noted, "patient functioned relatively ok apart from few behavioral issues without psychiatric medication in the community for more than 10 years." This suggests a lack of a severe mental illness and significant impairments in his functioning.*

The patient's history and symptoms were best captured by the other specified trauma and substance use diagnoses. Although impairments in his functioning were noted in the CTP (e.g., unemployment), the evidence suggests they were not due to a severe mental illness and could have stemmed from substance use or any other social, environmental, and/or medical factors. Of note, functional impairment is a component of most mental disorders, so the acknowledgement of impairment does not in and of itself mean that someone should be designated SMI yes.

Regarding the collateral received from his mother, the information provided was vague and not sufficient to change the patient's diagnosis or SMI designation. She commented on his history of trauma, which is what CHS treated him for.

Case 41 was also rated inappropriate for case management. CHS objects to this determination because the appropriate social work services were offered for the documented SMI rating and patient's clinical need. We believe these cases should only be found inappropriate for SMI appropriateness and not counted against CHS twice for the same finding.

Monitors' Response: The clinician completing the CTP concluded that "[t]rauma should be further explored with Pt. due to lack of privacy at the gate during this interview." When seen by the psychiatrist a week later, he demonstrated symptoms consistent with PTSD and a psychotic disorder. There was no effort to further assess his trauma history or to address the mother's report of more severe and longstanding illness during the remaining 6 weeks of his incarceration. Therefore, we find that his SMI assessment was inappropriate due to a failure to reconcile the disparate approaches to assessing his diagnosis and dysfunction. Because we are not finding that the SMI determination was definitively incorrect, we are changing the case management rating to ineligible.

Findings:

Referral/appointment: appropriate
SMI: inappropriate (inadequate consideration of his level of psychiatric dysfunction, failure to engage in case conference to resolve the lack of clarity as to his diagnosis/SMI rating)
Case Management: ineligible
Supportive Housing: ineligible

Case 42, August MO149, was a 43 year old man who was incarcerated from June 17 to August 13.

This CM was housed in GP at the time of his initial assessment. He was not produced for a CTP on July 2, July 3, or July 10. He was housed in GP when his CTP was eventually conducted on July 13, so he should have been considered a "GP case" even though the CTP assessed him as requiring MO level care. At his CTP, which was completed 10 days late on July 13, and he was diagnosed with bipolar 1; he was considered SMI. SW attempted to conduct a DCP on July 14, but the CM was not produced. At his timely DCP on July 16, he was referred to AB Medical, his prior provider. He was given a referral form, and the provider was contacted to confirm that they would accept the referral. He accepted a referral to CRAN, but this was not timely submitted. He was not homeless.

He was not produced for a SW follow up on August 9, because an "officer was not assigned to the DCP post." A note on August 12 indicated that the SW met with him at CRAN's request and that he was "offered an ATI mandate and in order to work with CRAN…he would need to be reoffered and accept CRAN." The CRAN record indicated that they did not receive a referral from SW until August 13, the day of release. The referral was delayed and only occurred because of the ATI offer. Although the referral was delayed, the CM did connect with CRAN after release and the case remained appropriate in that area.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case Management: appropriate
Supportive Housing: ineligible

Case 44, August MO162, was a 37 year old woman who was incarcerated from July 26 to August 31. She was housed in MO at the time of her timely CTP on August 1, where she was diagnosed with other specified schizophrenia; she was considered SMI. At her timely DCP on August 3 she was given a referral form for BronxCare, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral. Although she reported prior engagement in treatment at Metropolitan Hospital, she requested a referral in the Bronx near the Franklin Women's shelter she would be living in. She declined a CRAN referral and a supportive housing application.

She received an ACL on August 31, indicating an appointment at BronxCare for September 3 at 10:00AM. The appointment demonstrates that the program was contacted.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 46, August MO46, was a 46 year old man who was incarcerated from August 18, 2020 to August 11, 2021. After being stabilized at Mid-Hudson psychiatric hospital. He was housed in MO at the time of his timely CTP, where he was diagnosed with other specified schizophrenia, adjustment disorder, and AUD; he was not considered SMI. At his timely DCP on August 28, 2020, he was given a referral form to the KCH PORT clinic. There is no indication that SW attempted to contact the program to confirm that they would accept the referral.

At a TPR of September 23, 2020 his diagnosis was changed to recurrent major depressive disorder, and he was considered SMI yes. This should have, but did not, prompt a referral to SW for an updated DCP.

A 30-day follow up on November 25, 2020 indicated that SW was unaware of his change in SMI status, and no changes were made to the DCP. A note on December 16, 2020 quoted the CM: "I met with the court social worker, they are considering an inpatient program." A 30-day follow up note on December 22, 2020 again indicated that SW was unaware of the SMI change and were also unaware of the possible program being developed by the court. As a result, no updates to the DCP were made.

Court liaison notes on January 12 and January 21 indicated that the CM was still "pending acceptance" to mental health court. Subsequently, he told his prescriber on February 12 that he was interviewed for an outpatient program and that he still had his apartment. But on February 19, he informed staff that he lost his apartment.

A 30-day follow up note on February 24 indicated that SW was aware of his changed housing situation. It also noted that the CM's attorney was trying to secure an ATI for residential treatment. At this point, the class member indicated that he wanted an HRA 2010e application,

which social work subsequently submitted on March 2. The application was approved on March 8, and sent to two housing providers.

A DCP update on March 24 documented that the CM was in supportive housing prior to incarceration but lost the placement due to his extended incarceration. At this time, he refused mental health referrals but accepted a referral to CRAN for transitional case management and help with supportive housing.

A note from March 26 indicated the CM's acceptance to mental health court, which was working on inpatient referrals.

A 30-day follow up on May 11 indicated that the attorney informed the system that the court continued to work on outpatient program placement. A DCP update on August 9 indicated awareness that the CM was considered SMI yes, although the diagnosis was unchanged. At this point the plan was for him to go to Freedom House, which had been "arranged by the courts." As a result, no additional CRAN or housing referrals were necessary. An ACL was prepared on August 9 as well, and he was provided with walking medications and prescriptions as requested.

With respect to the CM's Medicaid, per HRA his case was "HX -CL" as of May 31, 2020 not long before the instant incarceration. His Medicaid prescreening, conducted on August 20, 2020, indicated that he needed a new application. The class member signed a Medicaid application on August 19, 2020. Per HRA, CHS's response was "sent to HRA August 20, 2020." A second Medicaid prescreening was conducted on November 17, 2020. This also indicated that a new application was needed, raising the question of the outcome of the first application. SW later created an updated DCP, which indicated that "a new application was submitted for patient's Medicaid," but did not explain why it was needed. There was no copy of this second application in the record provided. Likewise, the HRA dataset showed no indication of the later application. The entry "HX-CL" should have been overwritten with a new entry signifying HRA received one or both of these applications, approved them, and then suspended them. However, per the HRA dataset there was no Medicaid activation date. It appears that the class member did not have active Medicaid on or near release.

Findings:

Referral/appointment: inappropriate (PORT clinic inadequate for a class member with schizophrenia) → appropriate (ATI)
SMI: appropriate
Case Management: appropriate → ineligible (ATI)
Supportive Housing: appropriate → ineligible (residential ATI)

Case 47, September GPMEDS123, was a 56 year old man who was incarcerated from August 11 to September 24. He was housed in GP at the time of his CTP, which was 2 days late on September 2, and he was diagnosed with adjustment disorder and SUDs; he was not considered SMI. At his DCP, which was 1 day late on September 15, he requested two referrals, one to CASES Nathaniel Clinician and the other to Housing Works Re-entry program. Both programs were contacted to confirm their willingness and capacity to accept the referrals. However, the CM was not provided with referral forms indicating the details of the referrals.

***CHS Response**: CHS disagrees with the rating of Case 47 as inappropriate because "referrals not provided to class member." This determination should be changed to*

"appropriate" because, as documented in the DCP, the patient was indeed provided with referrals to CASES and Housing Works.

Monitors' Response: While the DCP documents that the referrals were *made*, there is no written indication that the class member was *given* a referral form or other physical document indicating that he received these referrals.

Findings:
Referral/appointment: inappropriate (referral forms not provided to class member)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 50, September GPMEDS287, was a 36 year old, undomiciled woman who was incarcerated from August 9 to September 18 on a parole violation. She was housed in GP at the time of her timely CTP on August 16, where she was diagnosed with other specified trauma and stressor disorder and SIMD; she was not considered SMI. At her timely DCP on August 17, she was given a referral form for VIP community services. The social worker contacted the program to confirm that they would accept the referral.

Both early assessments and her CTP documented symptoms of PTSD in each required domain: "irritability, nightmares, flashbacks, anger, avoidance of stimuli, fear of recurrence, mistrust," as well as a history of dependency and anxiety. There was no rationale for not making the PTSD diagnosis in light of this assessment. Since PTSD is a category one diagnosis, the SMI determination was inappropriate. Because this class member was incorrectly assessed as SMI no, she was not offered needed case management or assistance with supportive housing.

***CHS Response**: CHS disagrees with the rating of Case 50 as inappropriate for case management. The appropriate social work services were offered for the documented SMI rating and patient's clinical need.*

Monitors' Response: When cases are found to be SMI No and we determine that this is incorrect, the services that should have been offered to an SMI class member but were not will also be rated inappropriate. As we noted in Report 42 and subsequent reports, a finding that the class member is SMI is a predicate for more intensive services, and the failure to properly determine a person to be SMI results in SW not offering those services. While it may often be true that SW did the best they could given the incorrect assessment, defendants did not provide this class member a clinically appropriate discharge plan given his level of need.

Findings:
Referral/appointment: appropriate
SMI: inappropriate (PTSD should have been diagnosed based on documentation of the class member's symptoms)
Case Management: inappropriate
Supportive Housing: inappropriate

Case 51, September GPMEDS292, was a 43 year old man who was incarcerated from August 19 to September 22. In his IMHATP, he reported being treated with haloperidol injections monthly, and he reported being in treatment with an ACT team under an AOT order.

He was housed in GP at the time of his CTP on September 10, 4 days late, where he was diagnosed with schizophrenia and SUDs; he was considered SMI.

At his timely DCP on September 21, he refused referrals for MH care and supportive housing but accepted a CRAN referral. Despite his having previously received intensive case management, the social worker concluded that he did "not meet the criteria for a SPOA, F/ACT or AOT referral as he does not have documented high utilizations of inpatient psychiatric hospitalizations, violent charges, or noncompliance with treatment services."

On September 23, the same SW who completed the DCP emailed SPOA and care coordination "…to determine if the client has an active ACT team." This CM was only incarcerated for a short period of time. However, the delay in his CTP led to a delay in his DCP, such that it was only completed one day prior to release. This did not allow for communication with the prior ACT team in a timely manner (i.e., before the CM was released). Had the CTP been completed on the September 6 due date, the DCP would have been due on September 15, a full week prior to release, which would have permitted SW to communicate with the ACT team to determine if he could return there for ongoing treatment. In short, more targeted, clinically appropriate discharge planning could have taken place had the CTP been completed timely.

Findings:

Referral/appointment: inappropriate (SW did not contact the prior ACT to determine if he could return)
SMI: appropriate
Case Management: inappropriate (needed higher level case management and reconnection to prior ACT)
Supportive Housing: ineligible

Case 52, September GPNOMEDS291, was a 56 year old man who was incarcerated from August 20 to September 24. He was housed in GP at the time of his timely CTP on September 8, where he was diagnosed with adjustment disorder and cocaine use disorder; he was not considered SMI. A DCP was completed on September 28, was 11 days after it was due and 4 days after he was released. While the DCP was completed after he was released, the record includes a referral form for Queens Consultation Center signed and dated on September 15, indicating that the referral was made prior to release, though the DCP was not completed until after release. While the social worker noted that "the provider is known to the SW and clinically can provide the patient with services…," there is no indication that she attempted to contact the provider to determine if they would accept the referral.

Findings:

Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 53, September GPNOMEDS294, was a 55 year old man who was incarcerated from August 27 to September 29. He was housed in GP at the time of his timely CTP on September 8, where he was diagnosed with other specified trauma and stressor disorder and was not SMI. On September 17, having not been produced to the clinic "after numerous attempts," SW completed a DCP form without the class member's involvement, noting that he "will be offered a MH referral when he meets with DCP."

On September 28, the class member's parole warrant was lifted, and he was ordered to report to a parole office on 40th Street in Manhattan by noon the following day. SW saw him on September 29, the day of release, and completed an ACL which indicated that he was to reside in the Bellevue Shelter. No referral was provided, as he refused. The ACL was signed by SW at 10:51AM which would have hindered his ability to report to parole by noon.

Findings:

Referral/appointment: inappropriate (no referral offered)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 54, September MO43, was a 38 year old man who was incarcerated from August 9 to September 18. He was housed in MO. He did not have a CTP or a DCP.

At his August 10 psychiatric assessment, this class member was diagnosed with other specified trauma and stressor disorder and was SMI No even though he was floridly psychotic with manic symptoms. He was not seen again by either mental health or SW staff until September 17, when he was provided with an ACL accurately documenting that neither a CTP or DCP had been completed and that as a result the "…client was not able to meet with discharge planning for community referrals." With respect to housing, the ACL noted that he was going to what was described as a "private residence" located at 400 East 30th street, the address of the Bellevue men's shelter. The failure to complete a CTP led to the failure to complete the DCP as well; the SW completing the ACL apparently believed that because there was no CTP or DCP, they were precluded from attempting to give the class member a referral for ongoing mental health treatment in the community.

> ***CHS Response****: CHS… disagrees with the rating of Case 54 as inappropriate for case management and supportive housing because the patient was diagnosed SMI-No .*
>
> **Monitors' Response**: When cases are found to be SMI No and we determine that this is incorrect, the services that should have been offered to an SMI class member but were not will also be rated inappropriate. As we noted in Report 42 and subsequent reports, a finding that the class member is SMI is a predicate for more intensive services, and the failure to properly determine a person to be SMI results in SW not offering those services. While it may often be true that SW did the best they could given the incorrect assessment, defendants did not provide this class member a clinically appropriate discharge plan given his level of need.

Findings:
Referral/appointment: inappropriate (no referral provided)
SMI: inappropriate (incorrect diagnosis based on documented symptoms, SMI determination was never done because there was no CTP)
Case Management: inappropriate (case management not offered)
Supportive Housing: inappropriate (supported housing not offered to homeless class member)

Case 55, September MO50, was a 50 year old man who was incarcerated from August 6 to September 18. He was housed in MO at the time of his timely CTP on August 13, where he was diagnosed with borderline personality disorder and cannabis use disorder; despite the extensive functional limitations documented, he was not considered SMI. At his timely DCP on August 16, he was given a referral form for CASES Nathaniel clinic. There is no indication that the social worker attempted to contact the program to confirm that they would accept the referral. The SW also documented that he "meets criteria for SPOA/FACT" but that they would not initiate this referral because he had been determined by MH not to be SMI. Finally, the SW documented a prior 2010e approval good through April 28, 2022, based on an application that had been completed at Sing.

The DCP noted that this CM was treated in State prison as SMI yes, indicating he was considered level 1. On August 26, the prescriber added a diagnosis of bipolar I and prescribed prazosin for trauma symptoms while continuing the previous medications which included valproic acid.

A TPR of September 10 retained only the borderline personality and cannabis use diagnoses. On September 16, the prescriber retained the bipolar diagnosis along with the borderline personality and cannabis use diagnoses.

This CM should have been considered SMI based on the functional assessment completed in the CTP, the clear evidence of extreme emotional instability around the time of arrest and early in the incarceration, and the bipolar disorder diagnosis effective September 9.

With regard to his apparent quick stabilization, this is not uncommon for people with severe personality disorders when placed in highly structured settings. The stabilization is a feature of that structure, not a sign that he is not SMI. It is a form of attenuation for severe personality disorders.

At the time of the DCP, SW was aware that he should have been considered SMI based on the DOCCS level. In fact, SW believed that he required a SPOA referral but did not initiate one because of the incorrect SMI determination documented in the record. At minimum, this should have prompted a case conference where the treatment team considered his SMI status in light of the information obtained by SW. This demonstrated insufficient integration within the team. Additionally, the CM had an active HRA 2010e indicating that HRA considered him SMI. SW should have forwarded this approval to two providers even if they did not consider him to be SMI.

***CHS Response**: CHS disagrees with the rating of Case 55 as inappropriate. This was a difficult case, with evidence for and against SMI designation, and therefore we agree that a case conference would have been helpful in resolving the issue.*

Monitors' Response: Nothing in this response causes us to reconsider our finding as to the SMI determination. There is ample evidence that he was SMI, as documented above, and minimal evidence suggesting he should have been considered SMI-no.

CHS Response*: CHS also disagrees with the rating of inappropriate for case management and supportive housing because the patient was diagnosed as SMI-No.*

Monitors' Response: When cases are found to be SMI No and we determine that this is incorrect, the services that should have been offered to an SMI class member but were not will also be rated inappropriate. As we noted in Report 42 and subsequent reports, a finding that the class member is SMI is a predicate for more intensive services, and the failure to properly determine a person to be SMI results in SW not offering those services. While it may often be true that SW did the best they could given the incorrect assessment, defendants did not provide this class member a clinically appropriate discharge plan given his level of need.

Findings:

Referral/appointment: inappropriate (no contact with provider, and SW believed that he required FACT level of care)
SMI: inappropriate (See discussion above)
Case Management: inappropriate (SW believed he needed FACT level of care but did not initiate referral)
Supportive Housing: inappropriate (did not forward the prior approval to housing providers)
Focus of Remediation: This case underscores the need for better integration within the treatment team. A case conference would have been helpful in resolving the diagnostic question.

Case 56, September MO67, was a 32 year old undomiciled man who was incarcerated from August 3 to September 14. He was returned to jail from Mid-Hudson. He was housed in MO at the time of his timely CTP on August 10, where he was diagnosed with other specified bipolar and alcohol and cannabis use disorders; he was considered SMI. Both At his timely DCP on August 9, he was given a referral form for CASES ACT, and the social worker contacted the program to confirm that they would accept the referral. CASES responded that he had been screened and was found eligible but was on the wait list. He was also referred to CRAN, but he refused supportive housing. CASES also reported that he had been referred to Exodus for transitional housing after release.

Several subsequent notes indicated that this class member was released from court to Freedom House with ACT follow up which was suitable for his needs.

Findings:

Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case Management: appropriate → appropriate (ATI)
Supportive Housing: ineligible

Case 57, September MO72, was a 56 year old man who was incarcerated from August 10 to September 18. He was housed in MO. He did not have a CTP or a DCP.

This class member's initial mental health assessment was completed on August 12 and rendered a diagnosis of other specified trauma and stressor disorder. At the time of the assessment, he was placed on suicide watch which remained in effect until August 24 when he was transferred to GP. During his psychiatric assessment of August 17, he was diagnosed with adjustment disorder, other specified trauma and stressor disorder, and substance use disorders and was prescribed mirtazapine and melatonin.

Mental Health experienced significant difficulties in seeing this class member to complete his CTP. He was not produced by DOC on August 20 (twice), August 23, August 25, August 26, September 2, September 7, September 8, September 9, and September 10. An ACL on September 17, the day prior to his release, noted a primary diagnosis of other specified trauma and stressor disorder, and referred the class member to Realization Center. He was provided with the ACL, and his prescriptions were sent to a pharmacy in Brooklyn. There was no rationale for the referral to Realization, which was not contacted to ascertain its capacity or willingness to accept the referral. Although comprehensive assessments of his diagnosis and SMI status were thwarted by the multiple unsuccessful attempts to complete a CTP, there was no indication that the class member might have been SMI.

> ***CHS response****: CHS disagrees with the rating of Case 57 as inappropriate for referral/appointment. After the patient was admitted to DOC on 8/10/21 no CTP was completed, so there was no referral for a DCP. However, when the patient was unexpectedly released on 9/17/21 a referral was offered and documented in the aftercare letter.*
>
> **Monitors' response**: An ACL does not replace a comprehensive DCP as required by the stipulation. Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no rationale, no contact with the provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 59, September MO98, was a 28 year old man who was incarcerated from August 23 to September 24. He was housed in MO at the time of his timely CTP on September 3, where he was diagnosed with other specified trauma and stressor disorder and MJUD; he was not considered SMI. At his timely DCP on September 10, he was given a referral form for Metropolitan. There is no indication that the social worker attempted to contact the program to determine if they would accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 61, September MO144, was a 43 year old man who was incarcerated from August 19 to September 25. He was housed in MO. He did not have a CTP or a DCP.

At his initial mental health assessment, on August 24, this class member was diagnosed with other specified trauma and stressor disorder and designated SMI no. On August 31, a supervisor revised the diagnosis to adjustment disorder and borderline personality disorder. The psychiatric assessments scheduled for August 27 and September 2 were cancelled by CHS. The psychiatric assessment took place on September 8, and his diagnosis was amended to other specified trauma and stressor disorder, adjustment disorder, and substance use disorders. He was not produced for his CTP on September 8. A mental health note on September 20 gave a diagnosis of other specified trauma and stressor disorder as did a note on September 24, which again added a diagnosis of adjustment disorder.

No DCP was conducted in the context of no CTP, which did not occur due to problems with production. No referral was offered. Despite the diagnostic ambiguity that should have been explored further, especially regarding functional deficits in light of the supervisor's addition of a borderline personality diagnosis, overall, it did not appear that the class member was SMI.

***CHS Response**: CHS disagrees with the rating of Case 61 as inappropriate for referral/appointment. There was no CTP completed for the patient, and thus no referral for a DCP to be completed.*

Monitors' response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning.

Findings:
Referral/appointment: inappropriate (no DCP, no offer of MH referral)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 63, September MO186, was a 48 year old man who was incarcerated from August 16 to September 24.

He was housed initially in GP. At the time of his initial mental health assessment, on August 22, this class member was diagnosed with adjustment disorder and substance use disorders, although some functional impairments were also documented. He was not produced for a CTP on September 6 due to ongoing alarms and security risks. His CTP was completed on September 20, 14 days late, and he was diagnosed with delusional disorder; he was considered SMI. Because of his disorganized behavior and psychosis, he was transferred to C71. On September 21, a supervisor added the diagnosis of rule out schizophrenia. He did not have a DCP.

By September 22, he no longer appeared psychotic, and he was returned to GP.

No DCP was completed. An ACL was completed on September 24, the day of his release, at which time he refused a referral. The delayed CTP created substantial obstacles that interfered with SW's opportunity to provide adequate discharge planning to the class member. The case

illustrates the deleterious impact that the current aberrant systemic issues have on efforts to provide class members with clinically appropriate individualized discharge planning.

> ***CHS response****: CHS disagrees with the rating of Case 63 as inappropriate for referral/appointment, case management and supportive housing. The patient's CTP was completed on 9/20/21 but he was unexpectedly released on 9/24/21, before Social Work had a chance to meet with him for a DCP. Nevertheless, he refused a referral and stated that he wanted to go to a shelter.*
>
> **Monitors' response**: Because the CTP was completed late and shortly before the class member's release, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no DCP done, refused on day of release)
SMI: appropriate
Case Management: inappropriate (no DCP or offer of case management)
Supportive Housing: inappropriate (no DCP or offer of supportive housing)

Case 64, September MO288, was a 26 year old man who was incarcerated from August 10 to September 18. No CTP or DCP were done.

Mental Health attempted an initial assessment on August 17, but the CM was not produced. It was completed on August 19 with the plan to follow up in GP. The assessment noted that his housing situation was not known. He was not produced for psychiatric assessments on August 21, August 26, twice on August 27, August 30, August 31, September 2, September 3, and September 6, at which point he was transferred to C71. In the interim, he was not produced for his CTP on August 31, with DOC noting that he was "in route to GRVC [from OBCC]." CHS cancelled his CTP scheduled for September 7 because the CM was "…being detained by DOC security…reportedly was concealing a weapon." CHS again cancelled his scheduled mental health appointment on September 9 noting "staff out due to medical appointment."

The initial psychiatric assessment eventually took place on September 9, when the CM was diagnosed with schizophrenia and an SMI yes designation. He was noted to be "staying in housing provided by a mental health program." That same day, SW documented receiving a referral from the psychiatrist that the CM was SMI and needed DCP but "has yet to have his CTP completed to generate DCP involvement." Despite the specific referral from psychiatry, SW indicated that he "has not yet had his CTP completed to generate DCP involvement. Upon completion of the CTP patient will be scheduled to be seen."

Subsequently, the CM was not produced for various appointments including for a CTP and a DCP on September 14, and for psychiatry on September 16. A TPR of September 17 indicated that the CM was being bailed out but required a civil hold because he was decompensating. He was released without receiving any discharge planning services. Efforts to provide treatment and DCP were clearly hindered by repeated problems with producing the CM for services. However,

SW should have responded to the referral by the psychiatrist rather than waiting for an already late CTP to occur.

***CHS response**: CHS disagrees with the rating of Case 64 as inappropriate for referral/appointment, case management, and supportive housing. Patient was admitted to DOC custody on 8/12/21. No CTP was completed, nor was an expedited DCP referral received by Social Work, so the DCP was not completed and patient was then released unexpectedly on 9/18/21 and sent to Elmhurst per civil commit. Social Work was not able to meet with the patient for DCP and thus was not able to offer case management or supportive housing referrals before the time of his release/civil commit.*

Monitors' response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no DCP)
SMI: appropriate
Case Management: inappropriate (no DCP)
Supportive Housing: inappropriate (no DCP)

Case 65, September MO290, was a 34 year old man who was incarcerated from August 12 to September 25. He was housed in MO. No CTP or DCP were done.

This class member was not produced for his CTP on September 1. He was again not produced on September 8 when staff documented that "no DOC staff [was] available." On September 17, he was documented as having "refused from the housing area." An ACL of September 24 referred him to Queens Hospital outpatient clinic and noted his housing in Jamacia Queens. A SW note on September 24 indicated that the class member was released on bail. He signed the referral form and the ACL indicating that he received them. Queens Hospital Center was not contacted to ascertain whether they had the capacity and willingness to accept the referral.

***CHS Response**: CHS disagrees with the rating of Case 65 as inappropriate for referral/appointment. While a CTP was not completed, and therefore a DCP was not completed before patient's unexpected release on 9/24/21, the patient was indeed provided a referral at the time of his release.*

Monitors' Response: An ACL does not replace a comprehensive DCP as required by the stipulation. Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no rationale for the referral, no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 66, September MO293, was a 29 year old man who was incarcerated from August 23 to September 24. He was housed in MO at the time of his CTP on September 2, 2 days late, where he was diagnosed with adjustment disorder and alcohol use disorder; he was not considered SMI. At his timely DCP, on September 13, he was given a referral form for Promesa at his request, but the program was not contacted to ascertain whether it had the capacity and willingness to accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 67, August GPNOMEDS75, was a 41 year old man who was incarcerated from February 12 to August 18. He was housed in GP at the time of his timely CTP on March 15, where he was diagnosed with substance-induced psychotic disorder, rule out schizotypal personality disorder and delusional disorder; he was initially considered SMI, but that determination was later changed to "SMI: no." The CTP contained a thoughtful analysis of the differential diagnosis where only minimal functional impairments were noted. On March 24 the prescriber reviewed the case, documenting a normal mental status exam and that the class member no longer wanted medications as his symptoms were related to stopping methadone. Four prior incarcerations at Rikers Island were noted as was his lack of mental health treatment during any of the previous incarcerations. The conclusion was that his symptoms were substance induced, his diagnosis was changed to substance induced personality disorders, and his SMI designation was changed to no. An addendum to the CTP on April 21 noted the change to SMI no with the rationale that the diagnosis was drug induced psychotic disorder "…which is SMI no," and that the diagnosis of delusional disorder was a rule out at that time. The rationale supported this change in SMI designation.

His DCP on March 26 was 2 days late, and he was referred to Bellevue outpatient without an explanation as to the reason for the referral. There is no indication that the SW contacted the program to confirm that they would accept the referral. An August 2 letter from Argus Community indicated that they had accepted the class member to Striver House for residential treatment and requested medication. Staff complied with request, making the previously inappropriate referral appropriate for this ATI.

Findings:
Referral/appointment: inappropriate (no rationale, no contact) → appropriate (ATI)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 68, October GPMEDS20, was a 44 year old man who was incarcerated from May 30 to October 1. He was housed in GP at the time of his 32 day late CTP on August 2, where he was diagnosed with adjustment disorder and SUDs; he was not considered SMI. At his timely DCP, on August 11, he was referred to the Bronx Works Living Room at his request, based on his prior engagement with this program. SW saw this class member again on September 14, and he asked to contact Bronx Works. The SW called them and confirmed that the "client can return if there were no issues on his previous stay." The ACL of October 1 documented the same referrals.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 69, October GPMEDS28, was a 44 year old man who was incarcerated from August 15 to October 8. He was housed in GP at the time of his 2 day late CTP on September 8, where he was diagnosed with psychosis due to medical condition and SUDs; he was considered SMI. His DCP on September 23 was 6 days late. He was given a referral form for the Nathaniel clinic, which was contacted and confirmed that they would accept the referral. He accepted a CRAN referral, but this was never executed. He was found to have a 2010e approval active through November 25; the approval was forwarded to CRAN and two providers on September 2. SW also confirmed that the class member could return to his prior housing at Fountain House.

At this CM's TPR on October 4, his SMI rating was changed to "no" without explanation, though contemporaneous medication management notes include discussion of the possibility that his behavioral problems stemmed from a stroke in 2020 and that he may have had a delirium or a psychotic episode in the context of stroke and stroke recovery. We drew the inference that this change was made at the TPR because the diagnosis of psychosis due to medical condition disorder is not eligible for an SMI yes rating.

An October 8 SW note indicated a MOCJ placement. The SW contacted Fortune Society to see if the CM could return and was told to inform the CM that he should follow up with them after his release. He was provided with a referral form reflecting this.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case Management: ineligible
Supportive Housing: appropriate

Case 70, October GPMEDS60, was a 53 year old man who was incarcerated from August 9 to October 6. He was housed in GP at the time of his 12 day late CTP on September 9, where he was diagnosed with other specified trauma and stressor disorder; he was not considered SMI. No DCP was done.

The TPR of September 28 noted that there was no DCP and that the class member required a referral to SW, but this never took place.

Findings:
Referral/appointment: inappropriate (no DCP)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 72, October GPMEDS201, was a 59 year old man who was incarcerated from August 15 to October 21. He was housed in GP at the time of his 3 day late CTP on September 9, where he was diagnosed with adjustment disorder; he was not considered SMI. His DCP was not completed until November 4, 45 days late and 14 days after he was released. The DCP indicates a referral to HELP made on October 21, but other than this having been his prior provider, there is no rationale for this referral to a program in Harlem, quite distant from his residence in Queens. This same information is included in an ACL for this class member on October 21. He was provided with copies of his referral form and ACL, but there there's no indication that social work contacted the program to confirm that they would accept his return.

Findings:
Referral/appointment: inappropriate (no rationale, no contact with provider)
SMI: appropriate
Case Management: ineligible
Supportive Housing: ineligible

Case 74, October GPNOMEDS212, was a 37 year old man who was incarcerated from September 2 to October 13. This class member's medical screen, which led to a "stat" referral to mental health, was conducted on September 7 and noted a history of schizophrenia and prior treatment with olanzapine. The initial mental health assessment conducted the same day documented a history of schizoaffective disorder, as well as the class member's homelessness and current paranoia. It was noted that his poor decisions lead to continued involvement with the criminal justice system and recommended GP with mental health and psychiatry follow up.

He was housed in GP at the time of his CTP on October 12, where he was diagnosed with other specified trauma and stressor disorder and substance use disorders; he was not considered SMI. His CTP was 20 days late, and no explanation for the delay was included in the record. In an addendum of October 13, the diagnosis was changed to schizoaffective disorder and the SMI designation to yes.

No DCP was done. The only SW activity present in the chart was a Medicaid screen of September 7 and a declination form on October 13, the day of release, when he refused all services. No DCP was offered to this CM. The unexplained delay in completing the CTP precluded SW from conducting a full assessment for this SMI class member and completing a DCP. That was not remedied by the refusal of services on the day of release.

> ***CHS Response****: CHS disagrees with the rating of Case 74 as inappropriate for referral/appointment, case management, and supportive housing. The patient had a CTP completed on 10/12/21 but was released unexpectedly after hours on 10/13/21, prior to due date of the DCP.*

Monitors' Response: Because the CTP was completed 20 days late and shortly before the class member's release, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, the unexplained delayed completion of the CTP interfered with SW's ability to provide appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no DCP, refused on day of release)
SMI: appropriate
Case Management: inappropriate (no DCP, refused on day of release)
Supportive Housing: inappropriate (no DCP, refused on day of release)

Case 75, October MO6, was a 37 year old undomiciled man who was incarcerated from July 14 to October 9. He was housed in MO. Mental Health staff conducted the initial assessment on July 17 and noted numerous prior hospitalizations including at state psychiatric facilities. His prior diagnosis was schizophrenia and multiple substance use disorders; he had a history of parole mandated treatment. Mental Health staff diagnosed him with schizoaffective disorder and substance use disorder leading to a determination that he was SMI yes.

The initial psychiatric assessment took place on July 20, when the CM reported residing at Project Renewal. The psychiatrist contacted that program thereby learning that the class member had an active AOT order initiated while he was in an upstate prison. The AOT order included a diagnosis of PTSD and notes case management as well as outpatient treatment with BronxCare.

The record contains neither a CTP nor a DCP. The SW completed a supportive housing application and a Medicaid prescreen; the only other DCP activity in the record is a SW orientation on July 30, a refusal of a public assistance application, and a declination form on the day of release indicating that he refused a referral at that time. Because the referral was not offered until the CM was pending release that same day, the case was assessed as inappropriate in that area.

***CHS Response**: CHS disagrees with the rating of Case 75 as inappropriate for referral/appointment. A CTP was not completed so no DCP was completed, and patient was unexpectedly released after hours by Nursing.*

Monitors' Response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, the failure to complete the CTP interfered with SW's ability to provide appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no DCP, refused on day of release)
SMI: appropriate
Case Management: appropriate (reconnected to prior AOT and mandated case management)
Supportive Housing: appropriate

Case 76, October MO16, was a 32 year old man incarcerated from August 26 until October 1, 2021. At his medical screen on August 30, he was referred STAT to mental health due to a history of bipolar disorder and prior treatment at Mount Sinai. He was housed in GP when seen on September 4 for an IMHATP, at which time he was diagnosed with other specified bipolar disorder and was determined to be SMI. The clinician noted functional impairments including criminal justice involvement, SSI benefits, and multiple psychiatric admissions.

On September 7, criminal defense counsel contacted CHS indicating that he was not getting his medications and requesting that he be seen. A bridge order was written on September 10.

The class member saw a psychiatrist on September 13 and reported feeling better, but with continuing residual hallucinations. The psychiatrist confirmed the diagnosis and noted that the class member had an ICM. The psychiatrist called the ICM to obtain collateral information and left a message.

There are no other mental health contacts in this record. A CTP was not done.

There is a single SW note regarding a Medicaid prescreen, on September 15. A DCP was not done.

***CHS Response**: CHS disagrees with the rating of Case 76 as inappropriate for referral/appointment and case management. A CTP was not completed, so no DCP was completed and the patient was unexpectedly released after hours on 10/1/2021.*

Monitors' Response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, the failure to complete the CTP interfered with SW's ability to provide appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no DCP)
SMI: appropriate (based on the IMHATP and the psychiatric assessment)
Case management: inappropriate (no DCP)
Supportive housing: ineligible (not homeless)

Case 77, October MO27, was a 35 year old man incarcerated from July 14 until October 19, 2021. He was returned to jail after a stay at Kirby. At his timely CTP on July 19, he was diagnosed with schizoaffective disorder and was designated SMI.

SW attempted to meet with him on September 19, 21 and 23, but he refused and was noted to be "responding to [redacted] stimuli" (word redacted). A DCP form was completed on July 27, but he did not participate. He was said to have refused mental health referral and supportive housing. He was referred to AOT and SPOA.

At a 30-day follow up on August 27, he "continue[d] to refuse DCP."

On September 10, the mental health court requested a 2010e, and the class member agreed. The application was submitted on September 14 and approved on September 16. The approval was forwarded to three providers and to the mental health court on September 20.

By October 6, the class member was engaged in mental health court. A SW note on October 13 indicated that he was scheduled for release at his next court date on October 19, to go to a

mandated residential ATI placement at Harbor House. SW further documented this in an updated DCP on the day of release, and the next day, SW confirmed his arrival at Harbor House.
Findings:
Referral/appointment: ineligible → appropriate (ATI)
SMI: appropriate
Case management: appropriate → ineligible (ATI)
Supportive housing: appropriate → ineligible (residential ATI)

Case 79, October MO115, was a 22 year old man incarcerated from August 20 until October 26, 2021. He refused an IMHATP on August 23 and was not produced for an IMHATP on August 27. The IMHATP was completed on August 31, and he was seen by a prescriber the next day. The prescriber diagnosed PTSD, other specified trauma and stressor disorder, and cannabis use disorder, and designated him SMI, which was confirmed by the clinical supervisor.

On September 8, the class member had a timely CTP, where he was diagnosed with other specified trauma and stressor disorder and cannabis use disorder, with impairments in functioning including the inability to keep a job.

On September 14, the prescriber continued to diagnose the class member with PTSD, though the prescriber adopted the diagnosis of other specified trauma and stressor disorder on September 22. He appeared clinically stable and was on melatonin only (for sleep). He continued to appear relatively stable through the remainder of his incarceration.

At his timely DCP on September 16, he was referred to CASES and was provided a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

On October 7, SW learned from the attorney that he would likely be sentenced to time served and released at his court date on October 26.
Findings:
Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate (the overall record, including a PSYCKES report that indicates very little mental health involvement, supports the non-SMI determination)
Case management: ineligible
Supportive housing: ineligible

Case 82, October MO163, was a 57 year old man incarcerated on a parole violation from May 18 until October 18, 2021. His IMHATP was completed while he was in GP. However, on June 4, the day before the CTP would have been due, he was transferred to MO because of the possibility that he was recently on clozapine. Therefore, his CTP, completed on June 10, was timely, and he was diagnosed with schizophrenia and determined to be SMI.

The class member was not produced for DCP on June 16 and 17, the latter time because he was locked in for aggression. When seen by SW on June 21, he refused to participate.

A 30-day follow up did not occur on July 29 due to "safety concerns on the unit." When seen for a 30-day follow up on August 17, he was "not interested in talking about DCP."

However, on August 30, he approached SW asking for DCP services. At this time, he was referred to NY Psychotherapy and Counseling in the Bronx because it was "convenient" for him. The program confirmed they were accepting referrals. He also was referred to CRAN and

accepted a 2010e. The SW did not complete a full DCP, but rather documented in a brief progress note, and there is no rationale for the referral beyond its "convenience." She provided him with a referral form. The 2010e was submitted on September 15, and it was approved and forwarded to CRAN and two providers on September 17.

On the day of release, he was provided with an ACL listing his housing upon release as the Bellevue Shelter.

Findings:

Referral/appointment: inappropriate (insufficient rationale, and does not address the how the program will be convenient given his housing at the Bellevue shelter, at least in the immediate period after release)
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate

Case 83, October MO183, was a 52 year old man incarcerated on a parole violation from June 27 until October 18, 2021. At his timely CTP on July 2, he was diagnosed with schizoaffective disorder, other specified trauma and stressor disorder, and cocaine use disorder, and he was designated SMI. At his timely DCP on July 8, he was referred to St. Barnabas. SW contacted the program to confirm they would accept a referral, and the class member was given a referral form.

The SW also reached out to Mekong NYC, a Vietnamese advocacy organization, to try to find a Vietnamese speaking therapy provider, but this did not yield results. The SW referred him to CRAN and submitted a 2010e on July 14. The housing application was approved on July 19 and sent to CRAN and two providers.

CRAN did not do an intake during the incarceration, but a caseworker from his shelter in Brooklyn brought him in after release and he had a CRAN intake done.

Findings:

Referral/appointment: inappropriate (the DCP contains no rationale for the specific referral, and further does not address the distance between the program and the Bellevue shelter, which would be even more distant after he was transferred to a shelter in Brooklyn)
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate

Case 85, October MO195, was a 30 year old man incarcerated from July 27 until October 30, 2021. His initial screen on July 31 resulted in a STAT referral due to prior history of severe mental illness, inpatient and outpatient treatment, and current symptoms. When he was seen the first time by MH on August 5, MH contacted his prior outpatient provider, Jamaica Hospital outpatient, and learned that he was last seen in 2019, after which point he did not follow up. Based on his apparent psychosis, he was referred to the ER, where he was given a dose of medication and was not admitted.

The class member was not produced for a CTP on seven occasions between August 19 and September 10, and there are several bridge orders during this time as well.

The class member was seen for a medication reevaluation on October 5. However, he was again not produced for a CTP on October 20. No CTP was done.

On October 26, he had a SW orientation and agreed to a PA application, but no DCP was done. An ACL was prepared for him on October 29, and he refused a referral indicating that he "attends the Jamaica Hospital outpatient clinic." No other DCP services were offered.

***CHS response**: CHS disagrees with the rating of Case 85 as inappropriate for referral/appointment, case management, and supportive housing. A CTP was not completed, so no DCP was due. Patient was unexpectedly released and refused a referral on the day of release.*

Monitors' response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:

Referral/appointment: inappropriate (no DCP was done. While the class member refused a referral the day before release, his refusal was predicated on his active treatment in the community, which SW would have known was inaccurate had there been better communication among treatment team members)

SMI: appropriate (while there is no CTP, he was treated as having a SMI-qualifying diagnosis, which is appears reasonable based on the available documentation)

Case management: inappropriate (no DCP)

Supportive housing: inappropriate (no DCP)

Case 86, October MO 210, was a 22year old man incarcerated from August 28 until October 12, 2021. At his IMHATP on September 2, he was diagnosed with PTSD and rule out borderline personality disorder and was considered SMI. He was on suicide watch.

He was not produced for initial psychiatric assessments on September 8, 9, 10 and 11. On September 10, a CTP could not be completed "due to chaotic conditions in intake and no confidentiality."

The psychiatric assessment was completed on September 14, retaining the diagnosis of PTSD, and including a diagnosis of other personality disorder.

The class member was not produced for DCP on September 17 and 20. On September 22, the DCP form was completed "by chart review" and no services were offered as the class member was not present.

The CTP was completed on September 26, but the class member was uncooperative with the assessment. The CTP indicates significant psychiatric history and suicide/self-harm attempts, treatment with meds, hospitalizations, periods of juvenile detention, lack of sustained employment, and SSI until age 18. He was diagnosed with other specified trauma and stressor disorder, other specified disruptive, impulse-control and conduct disorder, and other personality disorder. The clinician noted that "[p]atient's functioning has been impaired by his mood/impulse symptoms…, but a full assessment of functionality [is] not possible as patient was uncooperative." They concluded at this point that he was not SMI.

Suicide watch was discontinued on September 28.

The class member was not produced for DCP on October 7 and 8. On the day of release, an ACL was prepared, and he refused a referral.

***CHS Response**: CHS disagrees with the rating of Case 86 as inappropriate for referral/appointment. DCP was completed for this patient by chart review on 9/22/21, due to his non-production. Patient then refused a referral on his day of release on 10/12/21.*

Monitors' response: Because the class member was not produced for his DCP, defendants completed a DCP form "by chart review" which offered no services. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

***CHS Response**: CHS… disagrees with the rating of inappropriate for case management because he was diagnosed as SMI-No.*

Monitors' Response: When cases are found to be SMI No and we determine that this is incorrect, the services that should have been offered to an SMI class member but were not will also be rated inappropriate. As we noted in Report 42 and subsequent reports, a finding that the class member is SMI is a predicate for more intensive services, and the failure to properly determine a person to be SMI results in SW not offering those services. While it may often be true that SW did the best they could given the incorrect assessment, defendants did not provide this class member a clinically appropriate discharge plan given his level of need.

Findings:
Referral/appointment: inappropriate (he was not offered a referral until the day of release)
SMI: inappropriate (both the initial mental health and the initial psychiatric assessments concluded that he had PTSD and was SMI. There is no later refutation of prior documentation that he met the full PTSD syndrome. The change to SMI no is without adequate explanation, and even if he does not have PTSD, there is ample evidence of substantial functional impairment even if his diagnosis did not automatically qualify as SMI. Therefore, SMI is both incorrect and also was changed to no without adequate rationale)
Case management: inappropriate (he was never offered case management)
Supportive housing: ineligible (not homeless)

Case 87, October MO214, was a 55 year old man incarcerated on a parole violation from September 13 until October 19, 2021. His first mental health contact was a suicide watch note on September 29. At his CTP, which was completed one day late on October 7, he was diagnosed with other specified depression and was determined to be SMI. On October 14, his diagnosis was changed to adjustment disorder, other specified trauma and stressor disorder, and possible cluster B personality disorder, and he was changed to not SMI. The clinician making this change explained her reasoning in detail.

A DCP was scheduled for October 15, but the appointment did not occur due to "CHS-Cancelled. Patient scheduled to a later date due to short staffing." No DCP was done. SW

prepared an ACL on the day of release providing the class member with referrals to Bellevue outpatient and to the Bellevue shelter, but prescriptions were sent to a pharmacy in the Bronx.

> ***CHS Response****: CHS disagrees with the rating of Case 87 as inappropriate for referral/appointment because there was no rationale for the referral. As noted in the DCP, "Patient was offered and accepted a community mental health treatment referral to Bellevue Hospital as he reports to be heading to the Bellevue Men's shelter."*
>
> **Monitors' Response**: The DCP to which defendants refer in their response is not included in the record provided for review. The ACL contains no rationale for why the specific referral was made, nor why his prescriptions were sent to a pharmacy distant from where he would be living.

Findings:
Referral/appointment: inappropriate (no rationale for the referral, no contact with the program, and the pharmacy is distant from both his prior living situation and from the shelter)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 88, September GPMED71, was a 56 year old woman incarcerated from July 9 until September 15, 2021. At her timely CTP on July 15, she was diagnosed with other specified trauma and stressor disorder and substance use disorders and was designated not SMI. She had a DCP form completed "by chart review" on July 16, but no substantive services were provided. She received a full DCP on July 30, 4 days late. The document is ambiguous. In one place, it indicates that she was referred to her prior transitional housing provider, Bailey House. On the next page, the document indicates that she reported a different prior provider. The document also indicates that she "accepted a MH community referral" and that she "declined DCP services." Finally, the DCP indicates that she "is working with Legal Aid to get back into Baily [sic] House."

Subsequently, an ACL on the day of discharge indicates that she was referred back to her prior hotel/shelter with treatment to be provided by Greenwich House Chemical Dependency Program. She was given an appointment for a few days later. We concluded that this was an ATI that was not clearly documented in the medical record.

Findings:
Referral/appointment: inappropriate (ambiguous referrals) → appropriate (ATI)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 89, September GPMEDS182, was a 56 year old man incarcerated from June 5 until September 15, 2021. At his CTP on July 5, which was completed 1 day late, he was diagnosed with other specified trauma and stressor disorder, cocaine induced depression, and substance use disorders. He was not SMI.

At his DCP, which was completed on the day of release, 63 days late, he was referred to Harlem Hospital. He signed a referral form on July 9, suggesting that there was SW action on the case prior to the DCP due date. There is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with program)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 90, September GPMEDS201, was a 21 year old man incarcerated from February 3 until September 28, 2021. At his CTP on March 8, 10 days late, he was diagnosed with other specified trauma and stressor disorder, other specified disruptive and conduct disorder, and hallucinogen induced psychosis. He was determined not to be SMI. He refused a referral at his initial, timely DCP on March 17.

He was hospitalized at Bellevue from April 1 until May 7. There, he signed an unexpected release form that included preprinted referrals to Bellevue outpatient clinic and the Bellevue shelter. While not included on the unexpected release form, he also declined a case management referral, according to the "declination of discharge planning" form. The hospital SW recurrently wrote that he was not sufficiently stable to complete a 2010e form, and that this decision would be reassessed based on his functional level. Despite clinical improvement during his hospitalization, they did not offer him a housing application.

After his return from the hospital, a new DCP was done on June 16. At this point, he was diagnosed with schizophrenia and was SMI. Collateral information was obtained from ONTRACK, a program designed for young people in the early stages of psychotic illness. He had been engaged there in 2018-19 and had prior supportive housing. SW referred him to SPOA referral and initiated a new housing application. He indicated he preferred to wait on a clinical referral pending the progress of his criminal case. The 2010e was submitted, but there is no approval in the record.

On August 12, he interviewed with Fortune Society for transitional housing, and an ACL on the day of release documents his release on a treatment mandate to Freedom House. He was also assigned to care coordination pending an IMT slot.

Findings:
Referral/appointment: ineligible → appropriate (ATI)
SMI: appropriate
Case management: appropriate
Supportive housing: inappropriate (SW did not follow up regarding the HRA's lack of response regarding the application that was submitted) → ineligible (residential ATI)

Case 91, September MO198, was a 28 year old man incarcerated from January 27 until September 28, 2021. At his timely CTP on February 18, he was diagnosed with schizophrenia and substance use disorders and was designated SMI. At his timely DCP on March 1, he was referred to Bellevue outpatient. He refused CRAN, but SW contacted SPOA and AOT as he

reported prior involvements. He accepted a 2010e, which was submitted on March 16 and approved on March 22. The approval was forwarded to two providers on June 21.

SW learned on March 4 that neither SPOA nor AOT had prior contact with the class member. On March 17, SW learned that Bellevue was "not taking new patient [sic] at this time;" this communication underscores the importance of contacting even programs that are widely believed to take all referrals, including those from the NYC jail system.

SW reengaged with the class member on June 8, reoffering DCP. He now accepted referrals to CRAN and to Metropolitan. SW confirmed that Metropolitan was taking referrals, and the class member signed a referral form.

At a 30-day follow up on August 25, the class member reported being satisfied with the current DCP but noted that he might be released to Harbor House. On September 3, an ACL was prepared indicating release to Harbor House on September 7, but he was not released on that date for reasons not documented in the medical record. Subsequently, on September 22, the MH court provided a letter indicating that he would be released on September 28 to Striver House. He was subsequently released to this ATI placement, which requested the supportive housing documents.

Findings:

Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case management: appropriate → ineligible (ATI)
Supportive housing: appropriate → appropriate (ATI requested supportive housing documents, presumably so that they could continue to seek permanent housing)

Case 92, September MO234, was a 35 year old man incarcerated from May 20 until September 3, 2021. At his CTP on June 18, 10 days late, he was diagnosed with schizophrenia and substance use disorders. At his timely DCP on June 24, he was referred to Promesa, to CRAN, and to SPOA/FACT. He refused supportive housing, saying he would stay with his mother. There is no indication that SW attempted to contact Promesa to confirm that they would accept the referral.

According to CRAN, on July 6 he indicated that he was "interested in HRA supportive housing services," and CRAN notified SW of this information.

SW met with the class member on July 13 but did not reoffer supportive housing.

No TPR raised the housing issue, though a July 15 TPR reiterated that he could live with his mother.

CRAN met with him again on August 3 and did not address housing.

At a 30-day follow up on August 31, he reported that he might be able to stay with an aunt, or that he would go to the Living Room (a drop-in center for homeless people). He accepted a 2010e at this point, but it was not done, and he was released on September 3.

***CHS Response**: CHS disagrees with the rating of Case 92 as inappropriate for supportive housing. The Monitors noting that the patient expressed interest on July 6, but SW did not follow up on this after being informed by CRAN, and the application was never done. CHS disagrees with the monitors' rationale. There is no documentation in CHER that supports the Monitors' claim that this patient "expressed interest" in supportive housing on 7/6/21. On the contrary, the patient refused supportive housing when offered.*

Monitors' Response: On July 6, at 1:03PM, CRAN informed SW by email that the class member "will be needing assistance with housing" and inquired as to whether SW had assisted him in completing a HRA 2010e application. At 4:57PM, SW responded by email that "he refused a housing application with us," apparently citing the earlier refusal at the DCP two weeks previously. These emails are included in the CRAN file, though CHS is correct that they are not included in the jail medical record. They made no further effort to respond to CRAN's query, and they did not follow up regarding housing until August 31, when SW documented his acceptance in a follow up contact. They did not complete the application prior to his release a few days later.

Findings:
Referral/appointment: inappropriate (no contact)
SMI: appropriate
Case management: appropriate
Supportive housing: inappropriate (he expressed interest on July 6, but SW did not follow up on this after being informed by CRAN, and the application was never done)

Case 93, September MO 239, was a 41 year old woman incarcerated from May 28 until September 7, 2021. At her timely CTP on June 6, she was diagnosed with schizoaffective disorder and was SMI. At her timely DCP on June 8, she was referred to Mountainside Hospital outpatient clinic (in New Jersey), her prior provider. She was provided with a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral. She declined case management and indicated that she was not homeless or in need of supportive housing.

On July 1, she requested a different referral and was referred to Rutgers/UBHC. She was again provided with a referral form, but again, there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Beginning at the end of July, there is some evidence that an ATI was in progress, and on September 3, a note regarding her e-prescriptions indicated that she would be "released to enter treatment at CASES NCS located in Brooklyn on 9/7/21 from Court." There were no other requests made of SW, and SW appeared to have no involvement in the development or implementation of this alternative discharge plan.

Findings:
Referral/appointment: inappropriate (no contact with either program in NJ)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 94, November GPMEDS 12, was a 40 year old man incarcerated on a parole violation from September 14 until November 2, 2021. At his timely CTP on October 8, he was diagnosed with other specified disruptive impulse-control and conduct disorder and substance use disorders, and he was not SMI. At his timely DCP on October 14, he was referred to Harlem East Life Plan (HELP). He was given a referral form and, later, an ACL. There is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with program)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 95, November GPMEDS 45, was a 47 year old man incarcerated from August 26 until November 16, 2021. After his medical screen on August 30, he was referred STAT to mental health, but he did not have an initial psychiatric assessment until October 14, 6 weeks later. There is no explanation in the record for this delay.

At his timely CTP on October 26, he was diagnosed with an anxiety disorder and substance use disorders and was not SMI. At his timely DCP on October 27, he was referred to the Better Living Center and was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with program)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 96, November GPMEDS 94, was a 26 year old man incarcerated from January 7 until November 3, 2021. At his CTP, which was not signed until February 22, 28 days after it was due, he was diagnosed with schizophrenia and was SMI. At his timely DCP on February 4, he was referred to his prior ACT provider. SW provided a referral form and attempted to contact the ACT provider, who communicated with SW a few days later. SW also referred him to South Beach PC outpatient clinic as a backup and provided a referral form. SW referred him to CRAN and AOT as well, and they submitted a 2010e application on February 11. This was approved on February 16 and sent to ACT, AOT, CRAN and two housing providers.

As the incarceration proceeded, several notes indicate that a potential ATI was in progress. SW documented several contacts with the MH court and with the class member's prior ACT program. SW also facilitated communication between the class member and the MH court staff.

On October 28, SW documented communication from the MH court that he would be released at court on November 3. In preparation, he was to have a phone conference with the Jewish Board for housing placement on November 1. He was referred to CASES for treatment. An ACL was prepared and provided to him memorializing these plans.

Findings:
Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate → appropriate (ATI)
Case management: appropriate → appropriate (ATI)
Supportive housing: appropriate → appropriate (ATI)

Case 98, November GPMEDS 168, was a 64 year old man incarcerated on September 10. He was released, as projected, on November 5, 2021. On September 12, he was referred STAT to mental health, but the record provided by CHS does not include an IMHATP or an IPATP. The record indicates neither that these were ever scheduled, nor an explanation for why they did not

occur. At his CTP, which was completed over a month later on October 20, he was diagnosed with other specified trauma and stressor disorder, anxiety, and opioid use disorder. He was not SMI.

At his timely DCP on October 25, he was referred to Realization, despite several indications that he had a prior provider, Housing Works. There is no explanation for the referral to Realization beyond its location which is quite close to at least one Housing Works location. Also, there is no rationale for the decision to not reconnect the CM to his prior provider.

> ***CHS Response****: CHS disagrees with the rating of Case 98 as inappropriate for referral/appointment because of "insufficient rationale." As noted in the DCP on 10/25/21, "Client accepted a MH referral to The Realization Center in Brooklyn, NY because he knew the area well and it was near his anticipated residence upon release. Client will benefit from complying with individual therapy and medication in order to reduce stress/restlessness. Client will benefit from identifying/discussing relapse triggers in order to abstain from substance abuse upon release."*
>
> **Monitors' Response**: As explained in detail above, SW failed to provide a reason why they did not refer the class member to his prior provider. The rationale quoted by CHS in their response does not address this concern.

Findings:
Referral/appointment: inappropriate (insufficient rationale)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 99, November GPNOMEDS 56, was a 28 year old man incarcerated from August 6 until November 29, 2021. He was referred STAT to MH, but he was not seen for an IMHATP until September 3. There is no explanation in the record for this delay. When he was approached on October 19 to complete a psychiatric assessment, he refused, reporting he anticipated release on November 29. This projected release date was confirmed in IIS.

His CTP was completed 31 days late, on October 19, and he was diagnosed with other specified trauma and stressor disorder, substance induced psychosis, and substance use disorders. He was not SMI. While the CTP documents some functional impairments, the extent to which these stem from his psychiatric disorder as opposed to his substance use is not documented. Given that he functioned adequately without medications during his nearly four-month incarceration, we concur with the rating as not SMI.

At his timely DCP on October 25, he was provided with an appointment at the Henry Street Settlement and was provided with a referral form.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 102, November MO 27, was a 24 year old man incarcerated from August 21 until November 19, 2021. After two scheduled CTP appointments for which he was not produced, on September 7 and 9, he was seen for his CTP on September 10, 12 days late. He was diagnosed with schizoaffective disorder and substance use disorder(s) and was SMI. His DCP was delayed by three appointments for which he was not produced, on September 16, 17 and 20. When it was completed one day late, on September 22, he refused a mental health referral. He was referred to CRAN and FACT, and he refused a 2010e as he thought he would not be homeless.

A few days later, SW learned that his attorney was seeking a program for him.

On November 17, SW documented the following communication from CRAN indicating that he would be released at his next court date, the next day. This communication indicated that CRAN had previously submitted AOT and SPOA referrals as well as a 2010e application in preparation for an ATI. In the absence of timely available housing, he was referred by CRAN to the Ft. Washington shelter, a mental health program shelter. CRAN was continuing to pursue residential placement, ACT and AOT as well as a mental health referral at BRC.

Findings:
Referral/appointment: ineligible → appropriate (ATI)
SMI: appropriate
Case management: appropriate
Supportive housing: ineligible → appropriate (ATI)

Case 103, November MO 61, was a 37 year old man incarcerated on a parole violation from January 8 until November 4, 2021. At his CTP, which was 3 days late on January 25, he was diagnosed with other specified disruptive, impulse-control and conduct disorder and with substance use disorders, and he was not SMI. The clinician documented "functional impairments in terms of multiple incarcerations, homelessness, unemployment, legal concerns and social/interpersonal relationships" but did not clearly attribute these to mental illness, substance use, or both. While the rationale for the diagnosis is quite good, the SMI determination did not account for the functional limitations noted.

On January 29, a few days later, the prescriber diagnosed him with bipolar disorder and modified his medication regimen. The bipolar diagnosis was adopted by subsequent staff, and on February 9, a TPR indicates that he was SMI.

At his DCP on February 10, 7 days late, he was referred to Fortune Society and to CRAN. SW contacted Fortune Society to confirm they would accept the referral, and they provided a referral form to the class member. SW also submitted a 2010e, which was approved on February 23 and sent to CRAN and two providers.

Numerous notes document the potential involvement of an ATI and/or MH court. In August, he asked to see SW and agreed to have SW confer with his criminal defense attorney regarding an ATI. SW saw him again on October 6, indicating that a referral had been initiated to ICL. On October 14, a clinician noted that "DCP is working with MH court to have him released to a respite program." An ACL was prepared and provided to the class member, reiterating the referrals to Fortune Society and to CRAN, and also noting the referral to the ICL respite program. The class member's attorney confirmed that he arrived at the respite center after release.

It is unclear whether this was a true ATI, or whether this represents a case in which SW collaborated effectively with the class member's attorney less formally. It appears that the respite center was a stopgap while he was on a wait list for Harbor House.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate

Case 104, November MO 70, was a 42 year old man incarcerated from March 16 until November 10, 2021. At his timely CTP on March 26, he was diagnosed with schizoaffective disorder and was SMI. At his timely DCP on April 1, he was referred to his prior ACT program, who was contacted and who confirmed that he could return. He was not given a referral form. The ACT program also noted that they were in touch with the class member's criminal defense attorney. He was also referred to CRAN and AOT.

The class member was admitted to BHPW for two weeks in mid-April, but no discharge planning was done there.

On three occasions in May, the 30-day follow up did not occur, twice due to safety reasons on the unit. When the 30-day follow up visit occurred on June 2, he was reminded of his prior ACT program, but no further discharge planning took place.

On July 2, an addendum to the discharge plan noted that he accepted a 2010e but refused a CRAN referral. The 2010e was approved on July 13 and forward it to ACT, AOT, CRAN, and two providers.

On July 15, the class member met with the CRAN liaison, and he decided that he wanted a referral to CRAN.

At his next 30-day follow up on August 2, SW noted that he had been accepted into MH court.

At his next 30-day follow up, on September 1, SW documented that "his legal team is in the process of referring him to ATIs. He reports that he had a meeting with Fortune Society and they accepted him but the wait list is long. He also informed that he will be interviewing with Harbor House soon, but he does not know when."

On October 1, the class member informed SW that he was offered a slot at Harbor House but that he rejected it because he was hoping for an outpatient ATI at Fortune Society.

On October 28, SW noted that MH court had obtained a bed for him at Fortune Society and then he would be released from court on his NCD of November 10. An aftercare letter was prepared for him on November 8, documenting the plan for his release to Fortune Society upon release from court.

Findings:
Referral/appointment: inappropriate (Referral not given to class member) → appropriate (ATI)
SMI: appropriate
Case management: appropriate → ineligible
Supportive housing: appropriate → ineligible

Case 105, November MO 74, was a 24 year old man who was incarcerated on a parole violation from June 29 until November 9, 2021. At his timely CTP on July 7, he was diagnosed with schizophrenia and cocaine use disorder and was SMI. SW attempted to see him on July 13 but were unable to do so for no documented reason. They again attempted to meet with him on July 15 but were unable to do so due to "safety concerns on the unit and patient's court appearance;" SW completed a DCP form on this date without seeing him. SW learned that he had a recent AOT filed but that the case was closed because he was not locatable in the community. SW indicated they would submit a new AOT application and indicated that they would meet with him at a later date to complete a DCP. SW confirmed a prior SPOA approval and the class member's placement on the FACT waitlist. Finally, they noted an active 2010e through May 2022.

An AOT application was completed on July 14.

At a 30-day follow up on August 4, SW indicated that they would connect with the class member's parole attorney to coordinate. Otherwise, there were "no changes to patient's DCP."

At a 30-day follow up on August 31, there were no updates to the DCP.

On October 14, SW reached out to the attorney and were advised that there were no updates and that his next court date was on November 4. Also on this date, the class member "reported he was awaiting a plea deal renegotiation" in a 30-day follow up visit.

On November 9, the day of release, SW prepared an ACL referring him to Realization Center outpatient drug treatment program at an address in the Bronx and to CRAN. The ACL reiterated the prior SPOA approval. A TPR on this date also noted that "parole has secured DCP housing/services sufficient to meet his needs upon discharge." A SW note on this date indicated he was going to the Bellevue Shelter and then to Exodus transitional housing. Subsequent communication from CHS indicated that CRAN never received "an official referral for this B&C."

This class member never had a comprehensive DCP. While the form was completed on July 15, the class member was not involved, and despite several SW contacts in the subsequent months, they never reoffered a DCP as they indicated they would do. Instead, they appeared to be relying on Parole and the class member's attorney. In the end, he did not receive a mandated plan, although a TPR completed "for the sole purpose of discontinuing the civil commitment" states that "parole has secured discharge planning housing/services sufficient to meet his needs upon discharge."

This case is an example of how problems with safety on the units and production of class members for needed services can disrupt SW services to the point where a class member does not receive an appropriate DCP.

***CHS Response**: CHS disagrees with the rating of Case 105 as inappropriate for referral/appointment. On the ACL the address appears to be Acacia network or Promesa. The plan appears to have been provided as part of parole mandated treatment and Social Work was in contact with PRDU… as documented in a DCP progress note.*

Monitors' Response: The record indicates that the PRDU SW was engaged with the case, but only in a single note indicating an upcoming parole hearing. There is no indication that this led to a mandated plan created by Parole. The ACL makes no mention of a mandated

plan. SW did not follow up to determine if the plan reportedly created by parole was a mandated plan.

***CHS Response**: CHS also disagrees with the rating of inappropriate for case management and disputes the Monitors' assertion that "the class member was known to have an active SPOA approval and referral to FACT, but SW did not do anything to move this along; SW never executed the referral to CRAN as indicated on the ACL." Social Work confirmed that SPOA approval was active on 7/12/21. A new AOT was needed, which Social Work submitted on 7/15/21 & uploaded. Social Work also notified SPOA/AOT, as indicated in the 11/9/21 DCP note. The patient did not sign the CRAN consents to complete a referral.*

Monitors' Response: We agree with regard to the SPOA referral/approval and are changing the rating to appropriate. We note, though, that because no DCP was ever done with the class member's participation, he was never offered a CRAN referral, and the fact that he "did not sigh consents" does not necessarily signify his refusal.

Findings:

Referral/appointment: inappropriate (Realization does not exist at the address provided, which is the address of another provider, as CHS points out; while Realization provides some clinical services, they do not provide the intensity of services needed by this class member)

SMI: appropriate

Case management: appropriate

Supportive housing: inappropriate (SW obtained the HRA approval but never forwarded it to providers or to a case management program)

Case 106, November MO 77, was a 68 year old man incarcerated from January 10 until November 19, 2021. At his timely CTP on January 26, he was diagnosed with schizoaffective disorder and cocaine use disorder and was SMI. At his DCP, which was completed one day late on February 5, he was referred to his prior provider, Merryland, and was given a referral form. The provider was contacted to confirm he could return. He was referred to CRAN as well. He accepted a 2010e which SW completed but did not submit until June 22. No reason for the delay was documented. The application was approved on June 29 and sent to CRAN and to two housing providers.

On February 22, SW documented contact from the class member's criminal defense attorney who was attempting to get the case moved into mental health court. In June, August, and September, SW noted that MH court was still working on a disposition.

In October, MH court arranged screening evaluations by Fortune Society, Exodus, and MOCJ. On November 5, he was noted to have been found eligible for these placements, but no beds were available. He was then screened for Harbor House. He was also pending placement in the CASES Nathaniel ACT program.

An ACL on November 19 documents his placement at the Faith Mission Crisis Center, a program operated by Argus Community, as a condition of his release to the community imposed by the MH court. He was also to be followed by the CASES ACT program.

Findings:
Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case management: appropriate → appropriate (ATI)
Supportive housing: appropriate → ineligible (ATI)

Case 107, November MO 80, was a 37 year old man incarcerated on a parole violation from April 15 until November 16, 2021. He was initially housed in GP, and his CTP due date was May 1. No effort was made to complete a CTP until May 15, when he was not produced. On May 17, he was transferred to MO due to continuing depression and anxiety. A CTP was attempted in GP on this date but could not be completed because of his transfer. The CTP was completed on May 18, 17 days late, and he was diagnosed with adjustment disorder and cannabis use disorder. He was not SMI.

At his timely DCP on May 26, he was referred to Brightpoint and was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral.

At his initial prescreen on May 21, he was found to be eligible for Medicaid only until July 31. PSYCKES indicated his Medicaid was "safety net." A second prescreen on September 21 resulted in his needing a new application, which SW submitted on his behalf. He was approved for Medicaid on September 28. HRA data indicates that his MA was in suspension status, and it was unsuspended on November 17, the day after he was released.

On August 6, SW learned that he took a plea and had an anticipated release date of November 15. His attorney believed he would be going upstate.

On August 15, he was taken to the hospital after "ingesting a large amount of pills." BHPW diagnosed him with adjustment disorder, rule out depression, and rule out "personality traits." Hospital SW did not engage in DCP activity during this eleven day admission.

SW saw him on October 18 at his request, noting that he wanted to know his release date. SW contacted the defense attorney and learned that the projected release date was November 15.

At a 90-day follow up on November 14, the SW reiterated the referral to Brightpoint, where the class member said he wanted to go for treatment even if he were staying at the Bellevue Shelter. No appointment was arranged for him at Brightpoint, nor was the program contacted to confirm they would accept the referral. The class member was given an ACL documenting the referral.

Findings:
Referral/appointment: inappropriate (no contact with program, no appointment for sentenced class member)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 108, November MO 99, was a 21 year old man incarcerated from September 19 until November 22, 2021. He was initially hospitalized, and at his timely psychosocial in the hospital on September 22, he was diagnosed with psychosis. No SMI rating was done. An unexpected release form was completed, but he refused to sign it.

Upon his return to Rikers Island, he refused COVID testing and was sent to CDU. There, he was diagnosed with other specified schizophrenia based on his history. He refused to engage with MH on several occasions, and he refused to take medication.

On October 12, he was not produced for a CTP based on a security risk.

On October 13, he was again not produced for a CTP as he was sleeping.

On October 14, he was cleared from CDU and transferred to the MO, but he refused to engage with clinicians. A CTP was completed based on "chart review" on October 18, as he continued to refuse to engage. His history was summarized and is typical of an early psychosis. He was diagnosed with other specified schizophrenia and was SMI.

On October 25 and 26, he refused to leave his housing area for a DCP. SW documented an active 2010e approval from March 2021 (during a previous incarceration). On November 2, SW forwarded the approval to two providers. He again was not produced for a DCP on this date, as he did again on November 4, 5, and 8. On the last occasion, SW noted that he "will be rescheduled for a 30-day follow up." According to IIS, he was released with time served on November 22.

Findings:
Referral/appointment: ineligible
SMI: appropriate
Case management: ineligible
Supportive housing: appropriate

Case 110, November MO 151, was a 32 year old man incarcerated on a parole violation from June 29 until November 17, 2021. At his CTP on July 13, 5 days late, he was diagnosed with schizoaffective disorder and was SMI. At his timely DCP on July 16, he was referred to his prior forensic ICM, who had initiated contact with SW on July 6. He was also noted to be on AOT mandating that he live with his mother and attend the Creedmoor outpatient psychiatric clinic and Samaritan Village for substance use disorder treatment.

At a 30-day follow up on August 17, he reported he would consider a 2010e but wanted to "continue to think about it."

On September 14, his parole attorney informed SW that the hearing was adjourned and that a mental health program was being considered for the class member. He was to be screened by Odyssey House on October 13, but this did not happen, and his hearing was again adjourned. The screening was rescheduled for October 22.

These plans did not come to fruition, and on November 17, an ACL was prepared indicating that he was referred back to Creedmoor outpatient and Samaritan Village. The ACL also notes the prior FICM, who remained involved with the class member throughout his incarceration, and continuing SPOA involvement for a potential ACT assignment. While he refused to sign the ACL, SW documented that they provided it to him.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: appropriate
Supportive housing: ineligible

Case 111, November MO 157, was a 38 year old woman incarcerated from August 13 to November 30, 2021. At her timely CTP on August 21, she was diagnosed with schizoaffective disorder and was SMI. At her timely DCP on August 25, she was referred to her prior ACT program for treatment and case management. SW provided her with a referral form and contacted the program to confirm that she could return. She was noted to live at Creedmoor, but she accepted a 2010e. The application was submitted on August 31 and approved on September 2. SW forwarded it to ACT and to two housing providers. Also on September 2, SW learned that she could not return to her prior housing placement at Creedmoor.

At a 30-day follow up on September 22, SW learned that TASC had referred her to Fortune Society for transitional housing. She was also referred to Able House. She was screened by Fortune Society on October 12. On November 3, she was screened by Able House but was found not suitable for their program. On November 9, TASC referred her to Anchor House. She continued to await a decision by Fortune Society.

On November 18, SW documented that there were no beds for women at Fortune Society for a month. She continued to await a decision by Anchor House. In an ACL on November 30, SW noted that she would be placed at Anchor House.

Findings:
Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case management: appropriate → ineligible (ATI)
Supportive housing: appropriate → ineligible (ATI)

Case 112, November MO 179, was a 41 year old man incarcerated from October 14 to November 19, 2021. At his timely CTP on November 2, he was diagnosed with an adjustment disorder and was not SMI. At his timely DCP on November 4, he was referred to Centerstone in Fayetteville, TN. He was given a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with program)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 113, November MO 180, was a 35 year old man incarcerated from October 15 to November 30, 2021. Although the case is labeled MO, the CM was housed in GP until after his CTP was completed. At his CTP on November 3, two days late, he was diagnosed with schizoaffective disorder and cocaine use disorder and was SMI. At his timely DCP on November 9, he was referred to Samaritan Village outpatient. He was given a referral form, and SW contacted the program to confirm they would accept the referral. He also accepted a CRAN referral, an AOT referral, and a 2010e, but these were never executed by SW.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: inappropriate (no referrals made)
Supportive housing: inappropriate (no application)

Case 114, October GPMEDS 50, was a 30 year old man incarcerated from June 7 until October 26, 2021. At his CTP on July 3, four days late, he was diagnosed with other specified trauma and stressor disorder and substance use disorders and was not SMI. At his timely DCP on July 9, he refused a referral.

An ACL prepared for him on October 21 indicates and he received an ATI from the Brooklyn treatment court mandating residential placement at Samaritan Village.

Findings:
Referral/appointment: ineligible → appropriate (ATI)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 116, October GPNOMEDS 97, was a 37 year old man incarcerated from September 8 until October 26, 2021. There are several court collateral notes in late September and early October reflecting the attempts of his attorney to have him seen by MH due to continuing symptoms and not being on his medication. Despite these attempts, he was not seen for a number of weeks, and he was never seen by a prescriber during his incarceration.

At his CTP on October 14, which was 14 days late, he was diagnosed with schizoaffective disorder and substance use disorders and was SMI. At his timely DCP on October 21, he was referred to Fortune Society in Harlem and was given a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral. The only rationale provided for the referral was that it was "close to his anticipated residence." This appears to be incorrect in that while there is one note indicating that he was previously living in and could return to housing in Harlem, most other notes indicate he is homeless (and he was referred to the Bellevue Shelter). Additionally, according to PSYCKES he previously lived in Staten Island.

At his DCP, he was also referred to CRAN. However, because of the delay in his CTP, CRAN was unable to see him prior to release to try to engage him. They were unable to locate him after release and closed his case.

> ***CHS Response****: CHS disagrees with the rating of Case 116 as inappropriate for referral/appointment. The clinical rationale indicates that Fortune Society was chosen due to location and that the patient would benefit from MH services, therapy, and medication and to target depression/anxiety and triggers for SUD. Fortune is a commonly used provider with a presence on the island and strong forensic focus.*
>
> **Monitors' Response**: Although it is unclear that Fortune Society is close to where he will be living, on re-review, we concluded that while the rationale for the referral was marginally

adequate, there remains no indication that SW attempted to contact the program to ensure that they would accept the referral.

***CHS Response**: CHS disagrees with the rating of inappropriate for case management. A CRAN referral was received by CRAN the day following the DCP (10/22/21), as noted in an admin note completed on 10/29. There was no delay in the referral.*

Monitors' Response: There is no admin note on 10/29 in the record provided for our review. The CRAN record begins with a note on 10/29 indicating that the case was assigned to a CRAN staff member on that date, three days after he was released from incarceration.

Findings:
Referral/appointment: inappropriate (no contact with provider)
SMI: appropriate
Case management: inappropriate (delay in referral)
Supportive housing: ineligible

Case 117, October MO 74, was a 27 year old man incarcerated from September 15, 2020 until October 19, 2021. At his timely CTP on September 21, he was diagnosed with schizophrenia, other specified trauma and stressor disorder, and substance use disorders, and he was SMI. At his timely DCP on September 28, he was referred to Brooklyn community PROS and was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral. SW completed and submitted a CRAN referral, but CRAN never received the referral. Subsequent communication from CHS indicated that CRAN had no file to provide. He also accepted a 2010e which SW submitted on September 28, 2020. He was approved on October 1, 2020 with an expiration date of September 30, 2021. The approval was sent to three housing providers on October 9, 2020.

The class member was reportedly a veteran, and SW initiated a VA benefits process with his consent. He interviewed with Veteran's Justice Outreach, and the VA confirmed his service and his honorable discharge.[2]

At a 30-day follow up on December 29, 2020, he reported that he believed he was going to be released on his next court date on January 5 to an 18-month inpatient program. This did not occur, and on January 26, SW documented that his case was moved into mental health court. For the next several months, SW documented a pending ATI.

At a 30-day follow up on April 28, the class member had a screening interview with Fortune Society. On May 26, he reported that he was anxious because he had not heard back regarding that interview.

On June 1, the 730 mobile team documented a "pending ATI through the Brooklyn mental health court. They are working on residential placement." The situation remained unchanged as of June 23, but the 730 mobile team indicated that Fortune Society had requested records to assist in a potential housing placement.

On July 23, he interviewed with CASES, and on July 26, he interviewed with Samaritan Village. The 730 team documented his acceptance by CASES Nathaniel ACT on August 11,

[2] Despite this, he does not appear on the VA dataset provided for class members released in October, 2021.

with a pending bed date at Exodus. He remained on the wait list for the next two months until his release date in mid-October. An ACL was prepared for him the day before release, indicating an intake appointment at CASES and housing at an Exodus motel.

***CHS Response**: CHS disagrees with the rating of Case 117 as inappropriate for supportive housing. The 2010e application expired within the same month of the patient's release, and ATI was already in process.*

Monitors' Response: The class member's placement in a transitional housing setting, even in the context of an ATI, does not obviate his need for supportive housing, a more permanent solution. While it is correct that his application expired less than a month prior to his release, as discussed in section II.A, above, HRA will accept reapplications "within sixty (60) days of the expiration date."

Findings:
Referral/appointment: inappropriate (no contact with program) → appropriate (ATI)
SMI: appropriate
Case management: inappropriate (CRAN referral not executed) → appropriate (ATI includes ACT)
Supportive housing: inappropriate (no re-application after the 2010e expired, and he was placed only in transitional housing, not a long-term residential placement)

Case 118, October MO 85, was a 39 year old man incarcerated from September 6 to October 19, 2021. At his initial screen, he reported receiving treatment at VIP Services, where he was prescribed quetiapine, risperidone, valproate, and mirtazapine for diagnoses including schizophrenia and depression. He had his IMHATP and his Psych Basic on September 11 at which time he told the clinician that he "need[s] to see DCP as soon as possible… to get another program and get out of here." He was housed in GP throughout his incarceration. Despite noting his prior involvement in both inpatient and outpatient treatment for schizophrenia, bipolar disorder, and depression, the Psych Basic concluded that he had a phencyclidine-induced psychosis.

On September 16, Brooklyn Defenders contacted CHS expressing concern that he was not getting his medications. They reiterated this concern on September 23. He had a bridge order on September 24, but was not seen because "CHS cancelled" the psychiatric follow up appointment. Brooklyn Defenders contacted CHS a third time on October 4, to reiterate their concern. On October 6, a psychiatrist documented having received information from a community pharmacy regarding his medications. On October 19, there was another bridge order written, but he was released on this date. He received neither a CTP or a DCP, nor did SW see him during the incarceration.

***CHS Response**: CHS disagrees with the rating of Case 118 as inappropriate for referral/appointment. As there was no CTP in this case, there was no DCP and thus no DCP referral. CHS actively attempted to complete the CTP, as evidenced by 5+ missed CTP visits documented in CHER.*

Monitors' Response: Because the CTP was not completed, defendants did not complete a DCP. The missed CTP visits cited by CHS are not included in the record they provided to us for review, nor are the reasons for these missed visits included in their current response. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, the failure to complete the CTP interfered with CHS's ability to provide appropriate discharge planning as required by the stipulation.

***Class Counsel's Response**: The SMI finding for Case 118 is "unable to rate" because the Class Member only saw a psychiatrist once and did not see other clinicians, so there was no opportunity to account for collateral information that should have prompted a reassessment of his diagnosis. (Report, Exhibit 1 at 53-54.) The SMI assessment in this case should have been rated inappropriate. Despite evidence from PSYCKES of prior inpatient and outpatient treatment for schizophrenia, bipolar disorder, and depression; previous treatment with Seroquel, Depakote, Risperdal, and Remeron; and the Class Member's receipt of SSI benefits, the Class Member was diagnosed with phencyclidine-induced psychosis. There was no reassessment of the Class Member's SMI status even though the Class Member's defense team contacted CHS three times. The defense team cited his previous diagnoses, requested that he receive all the medications he had been prescribed in the community, described his decompensation during incarceration, and eventually provided documentation of the medications prescribed in the community. Yet during the 38 days after the Class Member was diagnosed with phencyclidine-induced psychosis, the Class Member did not receive a CTP, and he was not seen for scheduled psychiatric medication reevaluation appointments – once because CHS cancelled the appointment and twice because he was not produced. Defendants failed to reevaluate the Class Member's SMI status because they failed to see him during scheduled appointments and did not conduct a CTP. Ample information in the record supports a finding that the SMI assessment was inappropriate.*

Monitors' Response: We concur with class counsel that there are significant indicia that this class member may have had a SMI-qualifying diagnosis. However, there are also substantial indications that his illness may have been related to substance use. The psychiatric prescriber considered prior diagnoses including some that would have qualified for an SMI designation, but she concluded that "his presentation is most consistent with a phencyclidine-induced psychotic disorder." The clinician who saw him concluded that the

> "Patient's functioning has been impaired by his mood sxs and use of substances as evidenced by multiple incarcerations and inability to maintain employment, but his functioning has not been significantly impaired as evidenced by his ability to maintain housing and benefits, and social supports. Patient's strength include that he appears cognitively intact, appears capable of asking for help and did not appear in acute distress."

Unfortunately, in part because the class member was not produced for two psychiatric follow up visits, the class member was not seen again during the remaining five weeks of his incarceration, and defendants were unable to do what is usually done in cases where the cause of the mental disorder is in question: conduct serial evaluations, gather collateral

information, and reconsider initial diagnoses as they learn more about their patient. We are not changing our determination, given the diagnostic ambiguities that are rather well documented in this case.

Findings:
Referral/appointment: inappropriate (never offered DCP or any other SW intervention despite his express request for SW services)
SMI: unable to rate (he saw a psychiatrist one time only, and did not see any other clinicians during the incarceration even after many contacts from Brooklyn Defenders expressing concern about his condition. This precluded any opportunity to account for collateral information that may have prompted a reassessment of his diagnosis)
Case management: ineligible
Supportive housing: ineligible

Case 119, October MO 113, was a 27 year old man incarcerated on a parole violation from October 20, 2020 until October 23, 2021.

The class member's first contact with mental health was on November 12, 2020, at which time he was transferred to MO for suicide watch. He was returned to GP on November 13, 2020, with a diagnosis of adjustment disorder. He was placed back on suicide watch on November 15, 2020. After this point he remained in MO. At his timely CTP on November 18, 2020, he was diagnosed with other specified trauma and stressor disorder and adjustment disorder and was not SMI. At his timely DCP on November 25, 2020, he was referred to Fortune Society and given a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

On December 30, 2020, clinical staff completing a TPR changed his diagnosis to PTSD based on his demonstrating the full symptom cluster. They changed him to SMI, with a very good explanation of why they were making this diagnostic change. However, in response to the questions "is SMI designation or diagnosis different from last TPR?" and "is the patient newly designated SMI?" the clinician completing the TPR checked "no."

SW saw the class member again on January 29, at which time they completed a new SW orientation and a new PA application. They did not re offer other DCP services at this time.

Subsequent TPRs indicate neither any review of the DCP nor any referral to SW for a DCP update given his change to SMI. SW did not see him again until August 20, seven months later, but on this occasion, there is no indication that they engaged in any DCP activity. They only noted that "his parole warrant was lifted and he's expected to be bailed out." SW did not see him after this point, and he was released on October 23 at 2:00 AM with an ACL done by medical.

This case demonstrated a serious breakdown in the functioning of the treatment team. The change in diagnosis and SMI status was well documented and explained, but this never translated to any updated DCP. After the diagnostic change, he was seen by SW only twice over a 10 month period. SW completed a PA application, indicating their awareness that he was SMI, but no other DCP activity took place. Specifically, he was not referred for case management although the change to SMI yes made him eligible. There was no indication that staff reviewed the prior DCP, and SW did not attempt to update it. This case demonstrated poor integration

between MH and SW and poor follow up by SW over the course of the class member's incarceration.

Findings:

Referral/appointment: inappropriate (no contact, insufficient rationale for the referral given his address that was right next to Metropolitan Hospital)
SMI: appropriate
Case management: inappropriate (not offered after he was changed to SMI)
Supportive housing: ineligible

Case 120, October MO 133, was a 27 year old man incarcerated from December 31, 2020 until October 13, 2021. He was initially in GP but was transferred to MO for suicide watch on January 4. At his timely CTP on January 7, he was diagnosed with substance use disorders and was not SMI. The CTP does not consider numerous indications of possible diagnoses that are automatically-SMI-qualifying and serious mental health involvement as summarized in PSYCKES. Despite the CTPs diagnosis, prescribers treated him for bipolar disorder with long acting injectable medication. He spent most of the remainder of his incarceration in GP.

At his timely DCP on January 15, he was referred to his prior care coordination program and to CCM for mental health treatment. He did not receive referral forms for either program, nor was there any indication that SW attempted to contact either program to confirm that they would accept the referrals. Because he was not considered SMI at this time, he was offered neither case management nor supportive housing.

For several months, there were no TPR's. On April 15, a prescriber wrote that they "will continue discussion with team for diagnostic review to consider diagnosis of schizoaffective disorder." At a TPR on this date, his diagnosis was changed to schizoaffective disorder, and his SMI status was changed to yes. However, SW never saw him again to update the DCP.

In October, a residential ATI was arranged at Acacia Network, and he was mandated to be admitted there directly from court.

In this case, the initial SMI assessment did not account for available collateral information that should have led them to consider more than just a substance use diagnosis. While they eventually corrected this, the case demonstrates a breakdown in the functioning of the treatment team similar to that observed in case 119.

Findings:

Referral/appointment: inappropriate (no contact with programs, no rationale for referrals) → appropriate (ATI)
SMI: appropriate (after the diagnostic change)
Case management: inappropriate → ineligible (ATI)
Supportive housing: inappropriate → ineligible (ATI)

Case 121, October MO 147, was a 21 year old man incarcerated from July 11 until October 8, 2021. He was initially in GP and was transferred to a PACE unit on July 22. A CTP could not be done on the due date because he was too symptomatic. He was referred to Bellevue on July 30 and August 2, but he was not admitted. The CTP was eventually completed on August 3, at which time he was diagnosed with bipolar disorder and mild intellectual disability and was SMI.

On August 4, he was admitted to BHPW, where he refused to sign the unexpected release form. He was never reoffered this form even after he began to stabilize clinically. Because this document is preprinted and not individualized to the specific needs of the class member, we are not considering it for the purpose of a timeliness analysis. He was discharged from the hospital on September 13.

SW saw him to provide a DCP on September 21, 40 days after it was due. At this time, SW "contacted CASES FACT… to determine if patient is able to return to their program." They were advised that because he had never completed intake, a new referral to SPOA was needed. SW referred him to Kings County hospital outpatient and provided him with a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral. They also referred him to CRAN, AOT and SPOA. They documented his active approval for supportive housing through April 26, 2022, but they did not forward the approval to any providers or to his case management program.

On October 6, SW completed an ACL that documented referrals to CASES and to ICL respite. He was provided with copies of these referrals. The CRAN record indicates that these arrangements had been made by the Brooklyn Defender Service SW.

After release, on October 18th, he was assigned to the CASES IMT.

Also after release, the CRAN record indicates that he did not go to ICL but instead returned to his prior provider, Create Inc. Young Adult Center.

***CHS Response**: CHS disagrees with the rating of Case 121 as inappropriate for supportive housing. ICL respite housing, which keeps residents up to 90 days and works on obtaining permanent housing in that time, was an appropriate placement.*

Monitors' Response: After reviewing this case and a prior communication from CHS regarding the respite center (email on January 12, 2022), we are changing the rating for supportive housing to appropriate, given that the ICL Respite provides assistance with supportive housing applications and "intensive housing case management."

Findings:

Referral/appointment: inappropriate (no contact with program, unclear why they did not refer him to his prior provider) → appropriate (ATI)
SMI: appropriate
Case management: appropriate
Supportive housing: inappropriate (did not forward approval to providers or case management) → appropriate

Case 122, October MO 192, was a 39 year old man incarcerated from July 21 until October 15, 2021. He was referred STAT to mental health on July 28, but he was not seen. On August 20, his criminal defense attorney contacted SW asking that he be seen for treatment of his psychosis. He was not seen, and he was subsequently hospitalized at BHPW from September 3 until September 13. At Bellevue, he was diagnosed with major depression with psychosis.

After he returned from Bellevue, he had an initial psychiatric assessment on September 16 which adopted the Bellevue diagnosis and indicated that he was SMI and homeless. He subsequently had numerous bridge orders but did not have any further mental health contacts. No

CTP was completed. He was seen by SW on October 15, the day of release. The ACL completed on this date provided referrals to Western Queens Consultation Center, to CRAN, and to the Fairfield Inn. SW did not offer an HRA 2010e.

This class member was seen only one time during his three month stay in the jail. He was not seen initially, despite a stat referral and contact from his criminal defense attorney. He was seen a few days after he returned from the hospital. No DCP was ever done, and he only saw SW on the day of release. SW did a good job of trying to scramble to meet his needs on his release date, especially in making a CRAN referral, but overall, the class member's DCP was inadequate to his need.

***CHS Response**: CHS disagrees with the rating of Case 122 as inappropriate for referral/appointment. A CTP was not completed, so the case was not referred to SW and a DCP was not scheduled.*

Monitors' Response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, the failure to complete the CTP interfered with SW's ability to provide appropriate discharge planning as required by the stipulation.

***CHS Response**: CHS… disagrees with the rating of inappropriate for supportive housing. A signed refusal for 2010E was scanned in the chart on 10/15/22.*

Monitors' Response: The class member was only offered, and refused, a supportive housing application on the day of release. Given the time it takes to complete a 2010e, offering the application only at the point of release is unlikely to lead to the class member's acceptance.

Findings:
Referral/appointment: inappropriate (no rationale for the referral, no contact with the program)
SMI: appropriate
Case management: appropriate
Supportive housing: inappropriate (refused on day of release)

Case 123, November GPMEDS 152, was a 45 year old woman incarcerated from June 30 to November 11, 2021. At her timely CTP on July 8, she was diagnosed with other specified persistent mood disorder and cocaine use disorder, but her diagnosis was changed by the supervisor to other specified trauma and stressor disorder and cocaine use disorder. She was not SMI. At her timely DCP on July 12, the class member was given a referral to New Horizons Counseling. SW contacted the program to confirm that they would accept the referral and provided a referral form to the class member.

On October 12, at a 90-day follow up, SW learned that the class member was working with the Osborne Association who was seeking a program placement at Odyssey House. An ACL on November 9 documents her acceptance by Odyssey House.

Findings:
Referral/appointment: appropriate → appropriate (ATI)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 124, November GPNOMEDS 43, was a 21 year old man incarcerated from October 1 until November 8, 2021. He was not seen for an initial assessment for over 10 days after his referral, and after several attempts (for which he was not produced by DOC). At his CTP, which was six days late on November 8 after several attempts for which he was not produced, he was diagnosed with other specified trauma and stressor disorder and was not SMI.

At his timely DCP, also on November 8, he was referred to Kings County hospital. The program was contacted to confirm that they would accept his referral, and SW provided him with a referral form.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 125, November MO 98, was a 48 year old man incarcerated from July 14, 2020 until November 16, 2021 after a period of treatment at Kirby. Notably, he had been incarcerated on the current case between Rikers and Kirby since 2016. At his timely CTP on July 17, he was diagnosed with schizoaffective disorder and was SMI. At his timely DCP on July 20, he refused referrals for mental health treatment, CRAN and supportive housing. SW submitted SPOA and AOT applications.

On July 24, SPOA responded to the application, noting that he was already a NYCSAFE consumer with an assigned case monitor.

SW maintained regular contact with the class member during his incarceration, with 30-day follow up notes nearly every month during his 16-month incarceration. These notes document his initial reluctance to engage that gradually evolved to an acceptance that he may be placed in an ATI. On October 13, he asked SW to refer him to inpatient MICA programs. SW referred him to both Harbor House and Samaritan Village, and he had a phone screening with Samaritan Village on November 9. At the last 30-day follow up, SW documented that he had been accepted by Harbor House on a voluntary basis. He accepted this referral and also accepted a 2010e at this point. However, he declined a referral to CRAN. The 2010e was approved on November 15.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: ineligible
Supportive housing: appropriate (late acceptance and approval limited time for forwarding the approval, and he is going into a residential placement)

Case 126, October GPNOMEDS 67, was a 44 year old man incarcerated from June 8 until October 13 2021. At his CTP, which was 22 days late on July 17 after several attempts for which

he was not produced by DOC, he was diagnosed with adjustment disorder and was not SMI. At his timely DCP on July 27, he was referred to the TRI center. SW contacted the program to ensure that they would accept the referral and provided the class member with a referral form.
Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 127, November MO 20, was a 41 year old woman incarcerated from March 23 until November 23, 2021. At her timely CTP on March 30, she was diagnosed with schizophrenia and was SMI. At her timely DCP on March 25, she declined all discharge planning. SW saw her several times during the spring and early summer, and she continued to refuse discharge planning.

After being found incompetent to stand trial, she was sent to Mid-Hudson where she was hospitalized from June 29 until October 5, 2021. A new intake was done on October 6, and she had another CTP that was timely. Her diagnosis was unchanged.

At a 30-day follow up on November 10, the class member indicated a plan to live with her sister in Far Rockaway. She reported involvement with Queens TASC and declined any changes to her DCP. On November 17, SW initiated AOT and SPOA applications. SW also completed a new DCP on this date documenting these referrals as well as a referral to SI CRAN. On November 18, she was placed on the wait list for FACT.

The class member was released on recognizance on November 23. A week after her release, there is a note indicating that Queens TASC obtained a treatment mandate at St. Johns Wellness and Recovery as well as confirming that she was living with her sister. Additionally, she had been assigned to care coordination at TSI.
Findings:
Referral/appointment: ineligible → appropriate (SW collaborated effectively with TASC in arranging for what ultimately became her ATI. While there is some indication that she was seen as needing FACT level services, she was placed on a wait list and given an alternative mandated treatment plan)
SMI: appropriate
Case management: appropriate (SPOA and AOT resulted in care coordination assignment)
Supportive housing: ineligible

Case 128, December GPMEDS 20, is a 39 year old man incarcerated from September 16 until December 16, 2021. At his timely CTP on October 8, he was diagnosed with other specified trauma and stressor disorder and substance use disorders. He was not SMI. At his timely DCP on October 15, he was referred to Jewish Board South Bronx Counseling Center. The class member was provided with a referral form, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

Findings:
Referral/appointment: inappropriate (no contact with program)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 129, December GPMEDS 56, was a 21 year old man incarcerated from October 22, 2019 until December 3, 2021. At his timely CTP on October 30, 2019, he was diagnosed with other specified trauma and stressor disorder, rule out PTSD, adjustment disorder, and cannabis use disorder. He was not SMI. He refused discharge planning at his timely DCP on November 6, 2019.

On July 13, 2021, his diagnosis was changed to bipolar disorder, and he was determined to be SMI. At a 30-day follow up on July 21, he accepted all DCP services. SW provided an updated DCP which referred him to Richmond University and CRAN. He was not given a referral form, and there is no indication that SW attempted to contact the program to confirm that they would accept the referral. He accepted a 2010e which was approved on July 26. SW sent it to CRAN and to two providers on July 29.

On October 5, an ATI had been arranged, and the class member was provided with an appointment at Applied Behavioral Services, a program appropriate for his specific issues.

Findings:
Referral/appointment: inappropriate (no contact with program, referral not provided to class member) → appropriate (ATI)
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate

Case 130, December GPMEDS 64, 34 year old man incarcerated from May 3 until December 16, 2021. At his timely CTP on May 26, he was diagnosed with other specified trauma and stressor disorder and substance use disorders. He was not SMI, although the clinician documented functional impairments including unemployment, conflicted relationships, and continuing substance use.

At his timely DCP on June 4, he was referred to Mind Body Wellness. SW provided a referral form and attempted to contact the program to confirm that they would accept the referral.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 131, December GPMEDS 151, was a 57 year old man incarcerated on a parole violation for September 29 until December 29, 2021. At his CTP on October 21, five days late, he was diagnosed with other specified trauma and stressor disorder and substance use disorders. He was documented as being "able to maintain adequate ADLs," but "functional impairment is evident due to inpatient admission, requires meds, and loss of housing." Despite these impairments, he was determined not to be SMI.

At his timely DCP on November 1, he was referred to the Family Health Center. SW provided him with a referral form and contacted the program to confirm that they would accept the referral. On the day of release, SW was able to obtain an appointment for him, even though his release was unplanned.

Findings:
Referral/appointment: appropriate
SMI: appropriate (Despite the indicators of possible functional impairments, the SMI rating was reasonable)
Case management: ineligible
Supportive housing: ineligible

Case 133, December GPNOMEDS 91, was a 20 year old man incarcerated from December 13, 2020 until December 2, 2021. At his CTP on May 12, 28 days late, he was diagnosed with an adjustment disorder and was not SMI.

A DCP form was completed, also on May 12, but the class member did not participate in the discharge planning process. SW did not follow up or see him during this year long incarceration.

Findings:
Referral/appointment: inappropriate (no DCP)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 134, December GPNOMEDS 94, was a 37 year old transgender woman incarcerated from November 2 until December 22, 2021. At her timely CTP on November 9, she was diagnosed with substance induced mood disorder and substance use disorders and was not SMI. At her timely DCP on November 13, she was referred to Ryan Chelsea Clinton and CASES, both of which were prior providers. She was given referral forms, but there is no indication that SW attempted to contact the program to confirm that they would accept the referral.

> ***CHS Response****: CHS disagrees with the rating of Case 134 as inappropriate for referral/appointment. CASES is a well-known and frequently utilized forensic MH service. CHS has ongoing coordination with the agency and they send regular email updates of program status and how to make general referrals.*
>
> **Monitors' Response**: CHS did not contact the programs to ascertain their willingness and capacity to accept the referral, as required by the Stipulation.

Findings:
Referral/appointment: inappropriate (no contact with providers)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 136, December MO 5, was a 38 year old woman incarcerated from November 12 until December 16, 2021. At her timely CTP on November 17, she was diagnosed with schizophrenia,

other specified trauma and stressor disorder, and substance use disorder. She was documented to meet the full syndrome required for a diagnosis of PTSD.

Based on the date of the CTP, her DCP was due on or before November 29. On this date, she was placed on suicide watch, and an intersystem transfer form was completed. In a TPR on December 1, she was noted not to have a DCP. The last note in the jail file is a bridge order on December 2, which was done because she was not produced by DOC.

According to the data set that we received, she was released from Bedford Hills Correctional Facility when her warrant was lifted on December 16. We requested but did not receive the Bedford Hills medical records for review.

***CHS Response**: CHS disagrees with the rating of Case 136 as inappropriate for referral/appointment, case management, and supportive housing. The patient was housed at Bedford, where OMH was responsible for the patient's reentry planning.*

Monitors' Response: The discharge planning in the records provided for review was inadequate.

Findings:
Referral/appointment: inappropriate (no DCP)
SMI: appropriate
Case management: inappropriate (no DCP)
Supportive housing: inappropriate (no DCP)

Case 137, December MO 9, was a 34 year old man incarcerated from October 30 until December 14, 2021. At his timely CTP on November 12, he was diagnosed with other specified trauma and stressor disorder and substance use disorders and was not SMI. At his timely DCP on November 19, he was referred to CASES and was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral. There was no further DCP activity during this incarceration.

Findings:
Referral/appointment: inappropriate (no contact with program)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 139, December MO 42, was a 25 year old woman incarcerated from September 14 until December 14, 2021. At her timely CTP on September 21, she was diagnosed with schizophrenia and was SMI. At her timely DCP on September 29, she refused referrals but was noted to have a prior program via an ATI as well as a prior ACT team assignment.

At a 30-day follow up on November 3, there was no discussion of discharge planning.

On November 15, there is a letter from Argus Community indicating that she was accepted by Harbor House. At a TPR on December 3, the class member discussed her placement at Harbor House, at which time she indicated that she would be going there on December 14. On December 7, SW prepared an ACL for her documenting this plan.

The medical record includes an updated DCP dated December 16, two days after her release. This document mostly repeats the information in the initial DCP but does note that she went to the ATI.

Findings:
Referral/appointment: ineligible → appropriate (ATI)
SMI: appropriate
Case management: ineligible
Supportive housing: ineligible

Case 140, December MO 44, was a 29 year old man incarcerated from Aug 27 until December 15, 2021. At his CTP on September 7, which was two days late, he was diagnosed with schizoaffective disorder and substance use disorders and was SMI. At his timely DCP on September 13, he was referred to the Bridge and was given a referral form. SW contacted the program to confirm that they would accept the referral. He was also referred to CRAN. He was noted to have previously been in supportive housing via Federation of Organizations. SW submitted a 2010e on September 14, and it was approved on September 15. SW forwarded the approval to CRAN and two housing providers.

On October 24, the class member told the clinician that he had been offered and accepted an outpatient program to which he would be mandated at court on December 15.

SW submitted an AOT application on October 26. The next day, SW documented that the class member is on the wait list at SPOA.

On November 16, the class member's defense attorney confirmed that he could return to his prior supportive housing placement if released at the December court date.

At a 30-day follow up on December 3, SW documented that he had been approved for ACT after release and noted that they would inform his attorney.

SW met with the class member on December 9 to update his DCP. He indicated that he still wanted to go to the Bridge. When SW called to obtain an appointment, they were told to call back on the following Monday, December 13. SW also informed SPOA of his upcoming release and asked about the availability of an ACT assignment.

On December 15, the day of release, SW contacted the Bridge and was told that they are no longer accepting new patients. The SW provided information to the class member's defense attorney SW regarding walk in times at CASES Nathaniel clinic on Tuesdays and Thursdays.

On December 16, SW documented his release the day before, and again contacted SPOA regarding a possible ACT assignment. On December 23, SW learned from AOT that he had been assigned to the VNSNY ACT program, and called the class member to inform him of this.

On January 6, 2022, the class member contacted CRAN and inform them that he was working with ACT. CRAN confirm this information on January 19, 2022.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate

Case 141, December MO 48, was a 42 year old man incarcerated from Aug 14 until December 13 2021. Despite having a STAT referral for a mental health assessment on August 19, his first MH contact did not occur until August 29, when he was placed on suicide watch. An IMHATP was attempted on August 31, but the class member was not produced due to an alarm. He did not have his initial assessment completed until September 3. Numerous suicide watch notes beginning on September 3 include a diagnosis of borderline personality. One of these notes, on September 7, states that he is "currently not SMI yes, instead patient appears to be exhibiting florid character pathology." This note concluded that he had an adjustment disorder but did not address the question of what personality disorder he had or whether it led to significant functional impairments or clinical distress.

At his timely CTP on September 10, he was diagnosed with adjustment disorder and substance use disorders. The clinician completing the CTP documented functional impairments, including "social impairment, adaptive dysfunction, inability to maintain relationships or employment, CJ involvement." The clinician did not clearly attribute these impairments to mental health problems, substance use disorders, or both. The clinician determined that he was not SMI.

The SW in MO attempted to do a DCP on September 20, but could not do so because he had been transferred to GP on September 17. A DCP was attempted on September 29, but he was not produced.

At his DCP on October 1, which was 10 days late, he was referred to Bellevue outpatient and was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral.

On October 15, a medication reevaluation reintroduced the diagnosis of borderline personality disorder. He returned to suicide watch not long after this. Some providers adopted this diagnosis, but others did not.

On December 13, he was back in GP, where they considered him to have an adjustment disorder, substance use disorders, and to be not SMI. He was involved in RCS who had arranged a referral to Fortune Society and who had been in contact with Fortune Society staff. SW prepared an ACL on this date indicating that he was referred to Fortune Society.

This case required a case conference on the question of whether he had borderline personality disorder. It appears highly likely that this was the correct diagnosis. There also needed to be a full reassessment of his functional impairments stemming from borderline personality disorder and a reconsideration of his SMI status. Staff documented significant functional impairments in the CTP, and he probably should have been considered SMI. Additionally, the statement that he is not SMI because he has character pathology reflects a misunderstanding of the SMI definition in the amended stipulation and demands further education for staff.[3]

***CHS Response**: CHS disagrees with the rating of Case 141 as inappropriate for SMI. We agree that the patient's diagnosis should have been conferenced to ensure consistency in the mental health notes. However, the patient's functioning did not appear to reach the level of*

[3] Under the amended stipulation, a class member with any DSM-5 diagnosis that does not automatically qualify for an SMI designation is to be considered SMI if the class member has "significant functional impairment or clinical distress as a result of [that] diagnosis," excluding diagnoses stemming from substance use or medical problems. There is no categorical exclusion for personality disorders or any other psychiatric illness.

being severe enough to warrant an SMI yes designation. For example, the patient was reportedly domiciled through HASA prior to his arrest, had previously attended college, and was able to maintain psychiatric stability in the community without mental health support. Although the CTP documented impairments in functioning, it is unclear if this was due to a personality disorder, his extensive history of substance use, or other social/environmental/ medical factors. Furthermore, functional impairment is a component of most mental disorders, so the acknowledgement of impairment does not in and of itself render an SMI yes designation.

Monitors Response: CHS agrees that there was ample evidence of ambiguity as to the class members' diagnosis and as to the cause of his documented functional impairments. They further agree that these ambiguities should have been resolved via a case conference. Our finding is not that the class member's SMI determination was *incorrect* but rather that the assessment of his SMI status was substantially flawed. Because of this, we rated the SMI determination inappropriate. But, because we are not finding that the class member should have been determined to be SMI, we did NOT find that the class member was eligible for supportive housing or case management.

Findings:
Referral/appointment: appropriate (SW was clearly aware of what RCS had initiated and adopted it in the end as the ultimate referral)
SMI: inappropriate (inadequate effort to resolve diagnostic uncertainty, inadequate consideration of functional impairments)
Case management: ineligible
Supportive housing: ineligible

Case 142, December MO 69, was a 32 year old man incarcerated from Sept 4 until December 9, 2021. He was not produced for a scheduled CTP on September 20 "due to security situation and escort officer leaving." On September 22 and again on October 1, the CTP did not occur because "CHS cancelled." The CTP finally occurred on October 6, 17 days late. The class member was diagnosed with schizoaffective disorder and was SMI.

At his DCP, which was 10 days late on October 28, the class member was referred to Exodus transitional community and to his prior ATI at Harbor House. The medical record includes a letter from Exodus documenting his acceptance. However, according to a court collateral note on this same date, the class member would not be able to return to Harbor House, and the mental health court was exploring other potential placements. He also accepted CRAN and SPOA referrals as well as a 2010e application. The SPOA and 2010e applications were not executed, and while there is no CRAN referral in the jail file, we did receive a CRAN record indicating he was referred on November 2.

On November 24, the class member informed the court liaison that a bed was available at Exodus and that he might be released on November 30. On November 30, the court confirmed that he could go to Exodus, pending bed availability.

In a 30-day follow up note on December 1, SW noted that he had an active HRA 2010e approval dated April 20. SW also noted his recent acceptance by Exodus.

An ACL prepared for him on December 6 documents the referral to Exodus, as well as referrals to CRAN and SPOA. According to a December 15 note by CRAN, he had entered treatment at Fortune Society, located very close to his Exodus hotel placement.

Findings:

Referral/appointment: appropriate
SMI: appropriate
Case management: inappropriate (SPOA application was not submitted)
Supportive housing: inappropriate (application not done) → inappropriate (while he was placed in a court mandated residential placement, he was placed only in transitional housing, not a long-term residential placement. He required a 2010e application, which was not done)

Case 143, December MO 75, was a 27 year old man incarcerated from July 18, 2020 until December 29, 2021. At his timely CTP on July 24, 2020, he was diagnosed with bipolar disorder and substance use disorders and was SMI. At his timely DCP on July 30, 2020, he was referred to CASES clinic pending a SPOA/ACT assignment, and he was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral. He was also referred to CRAN and SPOA for ACT. He reported that he was not homeless.

At 30-day follow ups in September and October 2020, no new discharge planning was done. He was not produced for a 30-day follow-up on December 15, 2020, and he had not taken medication for at least six weeks as of this point.

At 30-day follow ups in January, February and March, no changes were made to the DCP. He was not produced for 30-day follow ups in May or June due to "ongoing facility security issues." In July and August, he attended 30-day follow ups, but no changes were made to his DCP. He refused to engage in 30-day follow up appointments in September and October. On October 26, SW documented that CRAN was closing the case because he was refusing to engage with their assessment.

***CHS Response**: CHS disagrees with the rating of Case 143 as inappropriate for case management. As indicated on 8/27/20 note, SPOA was submitted and a URF was scanned into the chart on 8/26/21.*

Monitors' Response: There is no scanned copy of the URF in the record we reviewed. Based on a re-review of the record, the class member accepted CRAN and SPOA referrals at his DCP on 7/30/20. On 8/27/20, the same SW who completed the DCP wrote a progress note indicating that "CRAN/SPOA Transmitted on 8/7/2020". There is no explanation for the delayed referral, nor does the record indicate any follow up regarding the SPOA referral during the remaining 16 months of his incarceration. Nonetheless, the 8/27/20 progress note does indicate that the referral was made. Therefore, we are changing our rating for case management to appropriate.

Findings:
Referral/appointment: inappropriate (no contact with CASES, failed to submit a SPOA application for ACT level services)
SMI: appropriate
Case management: appropriate
Supportive housing: ineligible

Case 144, December MO 85, was a 26 year old man incarcerated from Aug 4 until December 8, 2021 after returning from a hospitalization at Kirby. At his CTP on August 16, four days late, he was diagnosed with unspecified schizophrenia and cannabis use disorder and was SMI. At his timely DCP on August 19, he was referred to CASES, CRAN and SPOA ACT, and he accepted a supportive housing application. However, he was not given a referral form. There is no indication that SW attempted to contact CASES to confirm that they would accept the referral, and there is no indication that SW submitted either the SPOA or the 2010e applications.

Several TPRs indicate a possible program placement, including at Exodus.

At A 30-day follow up on October 26, the class member expressed interest in a possible respite bed at ICL. No changes were made to the DCP.

There was no further SW interaction with the class member until the day of release, when the class member refused a referral.

Findings:
Referral/appointment: inappropriate (no contact with or referral form for CASES, no SPOA/ACT application was done)
SMI: appropriate
Case management: inappropriate (no SPOA/ACT application was done)
Supportive housing: inappropriate (no 2010e application was done)

Case 145, December MO 102, was a 36 year old man incarcerated from October 14 until December 13, 2021. His medical intake was completed on October 16, with a STAT referral to MH. He was not produced for an IMHATP on October 18 and twice on October 20. The IMHATP was done on October 21, at which time he was in GP. In this document, the clinician documented the CM's exposure to violence and indicated that he met full criteria for PTSD. Nonetheless, they concluded that he had other specified trauma and stressor disorder instead, noting that the "diagnosis should continue to be evaluated." They concluded that he was not SMI. He reported that he was not homeless.

He was seen for a medication evaluation on November 3, after legal aid reached out and asked for him to be seen.

He was not produced for a CTP on November 4.

MH saw him on November 7, but did not complete a CTP.

He was not produced twice for a CTP on November 8, first because he was in court, and later that day because he had been moved to GRVC.

On November 12, he refused to be produced for a CTP.

On November 16 a medication reevaluation was done.

On November 18 and again on December 1, he was not produced for a CTP.

A bridge order was written on December 7, as he was not produced for the medication reevaluation. On this same day, he was not produced for a SW orientation.

On December 9, he was not produced for a CTP, a SW orientation, or a medication reevaluation.

On December 10, he was again not produced for a SW orientation.

This class member never had a CTP or a DCP.

***CHS Response**: CHS disagrees with the rating of Case 145 as inappropriate for referral/appointment. A CTP was not completed, and thus a DCP was not due.*

Monitors' Response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (no DCP)
SMI: inappropriate (there was no follow up regarding the need to clarify the diagnosis)
Case management: there is insufficient information for us to rate this aspect of DCP
Supportive housing: ineligible

Case 146, December MO 115, was a 25 year old man incarcerated from May 28 until December 21, 2021. His initial MH or psychiatric assessment did not occur on numerous occasions from June 8 until mid-September due to numerous appointments for which he was not produced by DOC and on a few occasions because "CHS cancelled."

On September 8, his defense attorney provided information indicating that he had an IQ of 47 and a long history of treatment at Sheltering Arms residential program. In the community he had a diagnosis of moderate ID, Klinefelter's syndrome, bipolar disorder, and oppositional defiant disorder. The attorney also provided contact information for his residential program staff and his service coordinator at Care Design.

Despite having been "identified as a priority patient for the facility warden," he was not produced for a psychiatric assessment on September 9. a plan was made to transfer him to C71 to ensure that he would be seen, and he was finally assessed on September 10.

Also on September 10, SW confirmed his connection with OPWDD.

According to the court liaison on September 14, the class member was unable to return to his prior residential placement at Sheltering Arms. However, he had been approved by the DA for a program, and the court was currently seeking an appropriate program for him. SW did not complete and submit the 2010e application.

At his timely CTP on September 17, he was diagnosed with other specified bipolar disorder, moderate intellectual disability, and substance use disorders. At his timely DCP on September 24, he was referred to his prior service coordination program, Care Design, and was given a referral form. SW contacted Care Design to confirm that he could return. He was also referred to CRAN and accepted a supportive housing application.

On September 29, Sheltering Arms provided a letter indicating that he could return, noting several "safeguards" that they planned to implement for him. SW contacted them to confirm this

information on October 5. It appeared at this point that he would be released to return back to Sheltering Arms at his next court date on October 13.

However, he remained incarcerated after this point, and while subsequent notes suggest a possible alternative ATI, there is no indication in the medical record that another ATI was obtained. He was ultimately released on recognizance, having last been seen by SW for a 30-day follow up on October 22.

Notwithstanding the results below, we recommend that CHS and DOC review this case jointly, to learn from this near miss in a case of a seriously mentally ill and cognitively impaired class member.

***CHS Response**: CHS disagrees with the rating of Case 146 as inappropriate for supportive housing. Patient was housed at OPWDD IRA Sheltering Arms prior to incarceration and returned there upon release. Additionally, patient's SMI diagnosis was I/DD, which is ineligible for HRA 2010E as OPWDD services this population.*

Monitors' Response: We concur and are changing the rating to ineligible.

Findings:
Referral/appointment: appropriate (given his ID and prior history with service coordination, this is an appropriate referral)
SMI: appropriate
Case management: appropriate
Supportive housing: ineligible

Case 147, December MO 139, was a 25 year old man incarcerated from August 25 until December 3, 2021. He was not produced on numerous occasions throughout this incarceration for a CTP, a SW orientation, or medication reevaluations, and he required serial bridge orders. There is no indication that he saw any mental health staff after his initial assessment. When offered an ACL on the day of release, he declined a referral.

***CHS Response**: CHS disagrees with the rating of Case 147 as inappropriate for referral/appointment. A CTP was not completed for this patient, and thus a DCP was not due.*

Monitors' Response: Because the CTP was not completed, defendants did not complete a DCP. We have sympathy for the disadvantageous position CHS finds itself in due to the dysfunctional conditions in the jails; nonetheless, these dysfunctional conditions prevented CHS from providing appropriate discharge planning as required by the stipulation.

Findings:
Referral/appointment: inappropriate (refused on day of release but should have been seen much earlier)
SMI: appropriate (while there is no full functional assessment in the record, based on the information available, he did not have an automatically qualifying diagnosis and did not appear to be significantly functionally impaired or in significant clinical distress)
Case management: ineligible
Supportive housing: ineligible

Case 148, December GPMEDS 12, was a 53 year old man incarcerated on a parole violation from October 18 until December 14, 2021. At his timely CTP on November 16, he was diagnosed with schizoaffective disorder and was SMI. At his timely DCP on November 22, he was referred to BRC and Exodus and was given referral forms. The programs were contacted to confirm that they would accept the referrals. He was referred to CRAN as well. SW submitted a 2010e on November 30, but it had to be resubmitted on December 8 and again on December 13. The application was approved on December 15, the day after release. On December 17, SW sent the approval to three housing providers but not to CRAN.

His DCP was updated on December 14, the day of release, to include a referral to BRC and an appointment at Samaritan Village on December 16. This was not an alternative to incarceration, and the SW provided no information as to the reason for this change in the plan.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate (though it is not apparent why SW would not forward the approval to CRAN)

Case 149, December MO 63, was a 31 year old man incarcerated from February 14, 2020 until December 21, 2021. He was initially held at BHPW where he was diagnosed with schizophrenia at his timely psychosocial on February 17. No SMI determination was made at the hospital. He declined an unexpected release form on February 17, and recurrent SW notes indicate that he was "not yet stable" enough for them to complete a supportive housing application, even on the date they discharged him back to jail.

After his return to jail on March 17, 2020, a DCP was done on April 7, 2020. No MH referral was made at this time, pending more information regarding his case. He accepted referrals to CRAN and SPOA/IMT, but the CRAN referral was never executed. He also accepted a supportive housing application, which was submitted and approved on May 7, 2020.

At a 30-day follow up on September 2, 2020, he reported recently interviewing at Fortune Society for transitional housing and was accepted pending a release date. Additionally, SPOA found him eligible for FACT pending release. Finally, SW noted that he could return temporarily to live with his mother.

Various notes during the fall and winter of 2020-2021 indicate that both his state and federal defenders were working on a potential MH disposition of his cases.

At a 30-day follow up on March 17, he asked for and was provided with a copy of his 2010e approval. He reported that he might be going to an inpatient program. There were no updates at a 30-day follow up on April 27.

A second 2010e was submitted for him, and it was approved on June 4. In October, this approval was sent to CRAN, to SPOA, to two providers, and to his legal aid attorney.

On June 7, he reported having "successfully completed ICL forensic supportive housing interview." Over the next couple of months, SW met with him occasionally, noting that they were still working on a potential ATI.

On October 14, MH noted that he had a recent interview at CASES ACT.

A court collateral note on October 19 indicates that he "is being considered for ICL's supportive housing program," and he met with ICL on October 21.

An AOT application was initiated on October 27.

At a 30-day follow up on November 25, SW noted possible referrals to "MOCJ, Fortune and others," according to the class member. He was scheduled for court the following Monday.

On December 8, a court collateral note indicates an upcoming meeting with the judge regarding a potential reduction in bail. The class member had been accepted by CASES Nathaniel ACT at this point and was awaiting responses from Fountain House and Exodus. He was accepted by Fountain House on December 9, pending the approval of the judge and the DA. The plan consolidated, and by December 17, he was to go to CASES ACT for treatment and to Fountain House for transitional housing. This was memorialized in an ACL which he was given.

Findings:
Referral/appointment: appropriate
SMI: appropriate
Case management: appropriate
Supportive housing: appropriate

Case 150, December MO 130, was a 59 year old man incarcerated from Aug 5 until December 3, 2021. At his timely CTP on August 25, he was diagnosed with other specified schizophrenia and was SMI.

A DCP was completed based on chart review only on September 3, because he was not produced to the clinic. No discharge planning was provided.

SW saw him for a 30-day follow up on October 21. They reoffered DCP because the prior DCP was completed by chart review. SW completed a DCP on this date, 48 days late. SW noted that he had been in the military and had received services from the VA, including a "VA coordinator." He was referred to Realization and was given a referral form. There is no indication that SW attempted to contact the program to confirm that they would accept the referral. He accepted a CRAN referral and a 2010e. The 2010e was approved on November 4 and sent to CRAN and two housing providers.

In a note on October 26, SW documented confirmation from the VA that he was eligible for and had previously received services at multiple VAs around the country.[4]

The CRAN referral was not made until December 1.

In an ACL on December 3, SW documented an appointment at Realization at 10:00 AM but with no date provided. He was to live at the Bellevue shelter.

[4] Despite this, he does not appear on the VA dataset provided for class members released in December, 2021.

After release, he contacted CRAN, by which point he was at Exodus, confirmed by CRAN who spoke with the Exodus case manager. The CRAN records indicate that the appointment at Realization was scheduled on December 6, which was not noted on the ACL.

***CHS Response**: CHS disagrees with the rating of Case 150 as inappropriate for referral/appointment. As noted in the record, there were multiple contacts with the VA coordinator as well as direct discussions with the patient on the subject. Patient was aware that he was eligible to receive treatment at the VA. As to ACL, a 11/30/21 DCP note has a 10 AM appointment listed.*

Monitors' Response: This response does not address the basis for the findings, including that Realization does not provide an adequate level of care and that the appointment has a time but no date.

Findings:

Referral/appointment: inappropriate (While Realization has a specialized program for veterans, it does not provide the level of treatment required by people who are SMI. The ACL did not have a date for his appointment)

SMI: appropriate

Case management: appropriate (despite the delayed referral, he did connect with them after release)

Supportive housing: appropriate

ATTORNEY'S AFFIRMATION OF SERVICE

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

I, HENRY A. DLUGACZ, an attorney at law of the state of New York, and one of the Compliance Monitors in the matter of Brad H *et. al.,* against The City of New York, *et al.,* being duly sworn, say, depose, and affirm under penalty of perjury that on the 30th day of June 2022, I caused to be served upon the parties named below the FORTY-NINTH REGULAR REPORT OF THE MONITORS by electronic filing, by electronic mail, and for those who requested, by United States Mail in a pre-paid envelope addressed to the following persons at the last known address set forth after each name:

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Affirmed this 30th
day of June 2022

/S/ Henry A. Dlugacz

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