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January 12, 2012

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U.S. Department of Justice
P.O. Box 66400
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From: Jeffrey L. Metzner, M.D.

Re: *USA v Erie County et al.*

As you are aware, from December 5-9, 2011, I site visited the Erie County Holding Center (ECHC). During the morning of December 8, 2011, I also site visited the Erie County Correctional Facility (ECCF). I toured the Erie County Medical Center's Secure Psychiatric Service Unit during the afternoon of December 8, 2011. First Deputy Superintendent/Compliance Michael Reardon and Michael Ranney (Director of Forensic Health Services) accompanied me throughout this site visit.

Sources of information utilized in compiling this report included review of the following documents:

1. the July 2009 Department of Justice's Findings Letter,
2. the June 18, 2010 Stipulated Settlement Agreement and Order concerning Suicide Prevention and Related Mental Health Issues,
3. pertinent Forensic Mental Health Services' policies and procedures and program descriptions,
4. the Joint Compliance Officer's November 2010, March 2011 and July 2011 Reports,
5. the August 2011 Stipulated Order of Dismissal,
6. draft policies regarding the following areas:
    a. comprehensive suicide risk assessment form,
    b. constant observation follow-up,
    c. SOP mental health assessment and admission (intake),
    d. SOP community meeting,

e. SOP progress notes,
f. as of the treatment plan, and
g. quality management,

7. minutes of the ECHC leadership team,
8. minutes of the suicide prevention workgroup,
9. minutes of the detox workgroup,
10. the ECHC quarterly performance review (10/24/2011),
11. the FMH-constant observation review report (third quarter 2011),
12. mortality and morbidity reports, and
13. the healthcare records of 25 inmates.

During the site visits, I had the opportunity to meet with the following persons:

1. First Deputy Superintendent/Compliance Michael Reardon,
2. Philip Endress, LCSW (Commissioner, DMH),
3. Michael Ranney, M.S., CRC (Director of Forensic Health Services),
4. John Rodriguez, (Chief of Operations),
5. Tom Diina (Superintendent, ECCF),
6. Ed Heidelberger, M.D. (Medical Director),
7. Robert Sobon (Director of Correctional Health Services),
8. Michael Cummings, M.D.,
9. Heidi Milch (Community Corrections of New York),
10. Corrine Posluszny, R.N. (Head Nurse, ECCF),
11. Ildiko (Nicky) Fera MS, CRC, LMHC,
12. Bonnie L McLaughlin, MS, LMHC,
13. Ronald Schoelerman, LMSW,
14. Evelyn Coggins, M.D. (Chief Forensic Psychiatrist),
15. Daniel Antonius, Ph.D.,
16. nursing staff in the reception (intake) unit,
17. correctional officers in various housing units, and
1. most of the line mental health staff.

Overview

The ECHC is a pre-trial detention center located in Buffalo, New York. The Eric County Correctional Center (ECCF) is a correctional facility located in Alden, New York. Both facilities are under the authority of Erie County Sheriff and are managed by the Superintendent of the County's Jail Management Division (JMD).

Approximately 23,000 people are processed through the two facilities each year. The Erie County Department of Health has been providing medical and dental services to both facilities for about the past four years, while the Erie County Department of Mental Health Services, through the Adult Forensic Mental Health Clinic, has provided the mental health services for both facilities for many years. ECHC and ECCF inmates may also be admitted to the Erie

County Medical Center's Secure Psychiatric Service Unit, which has security staffing by in-hospital sheriff's deputies.

During the December 8, 2011 visit, 196 of the 496 inmates at ECHC (which included 15 female inmates) were on the mental health caseload and 226 of the 800 inmates (which included 102 female inmates) at ECCF were receiving some form of mental health treatment. The total ECHC and ECCF average daily populations during 2010 was reported to be 1350 inmates.

During December 8, 2011 there were 14 inmates on constant observation status at ECHC. The census in the Delta North and Delta East units was 24 inmates.

The numbers of inmates receiving mental health treatment during 2010 and part of 2011 were as follows:

2010	**ECHC**	**ECCF**
January	194	129
February	183	125
March	206	131
April	203	128
May	206	136
June	195	134
July	218	137
August	205	142
September	209	148
October	235	153
November	227	173
December	189	202
2011		
September	218	200
October	213	243
November	221	210

Staffing

Appendix I provides relevant staffing information for ECHC and ECCF. ECHC has 15.0 FTE mental health clinicians and 2.25 FTE psychiatrists or a nurse practitioner. During the site visit**,** ~12.0 FTE mental health clinicians were assigned to provide services at ECHC in addition to a 1.0 FTE discharge planner. There was no clerical staff within ECHC assigned to the mental health services, which has been problematic.

Erie County Holding Center (ECHC)

ECHC is the second largest pre-trial detention facility in New York. ECHC was built to house 680 inmates with a design combination of pods, open bay dorms, and traditional linear-type cells. ECHC's average daily census generally has been around 500 inmates with an average length of stay for arraigned male inmates being 11.4 days and arraigned female inmates being 3.21 days. The linear housing units were built during the 1920s and the newer pod units opened during 1986.

ECHC houses inmates who have not yet been arraigned, classified as maximum security and/or have a serious mental illness. There is also a 30 bed capacity housing unit for inmates requiring detoxification that is staffed for medical purposes by the Department of Health.

The Intake Healthcare Screening Process

In the booking area, the first three pages of the Correctional Medical Intake Screening form (see Appendix II) are completed by a registered nurse ("Nurse A") for all inmates initially booked into the ECHC. In addition, the nurse will complete Form 330 (the Suicide Prevention Screening Guidelines form-see Appendix III). The transporting officers, for some of these inmates, may bring a completed Suicide Prevention Screening Guidelines form from the sending facility and/or share relevant health care information with the ECHC booking officer. Nurse A also attempts to verify reported medications. If medications are verified at that time, a 14 day medication order is generally obtained from a covering non-psychiatrist physician or nurse practioner.

Following the initial healthcare screening and classification processes, the inmate will be sent to a housing unit separate from the housing units for inmates who have been arraigned except for inmates determined to be a significant suicide risk based on results of the Suicide Prevention Screening Guidelines assessment. Such inmates during peak hours (11 AM - 7 PM) will be seen promptly by a forensic mental health specialist, who determines whether close observation status or other special housing is required. This relatively new process has significantly reduced the number of inmates placed on close observation status due to waiting for an assessment by a QMHP. The average number of such inmates or close observation status has been reduced from about 17 inmates per day to usually 12 inmates per day.

In general, inmates are arraigned within 24 hours of booking. Upon return from the arraignment process, they are again screened by nursing staff (i.e. the so-called "Nurse B" assessment), which involves completion of the Correctional Medical Intake Screening form and re-administration of the Suicide Prevention Screening Guidelines form. Attempts to verify medications occur, when clinically indicated, during this screening process and mental health referrals are initiated as indicated. The Suicide Prevention Screening Guidelines form is again administered to all inmates returning from court after being sentenced via this "Nurse B" screening process.

Related to a change in a contract with the City of Buffalo that will be effective reportedly around April 2012, the number of daily intakes will be decreased by at least 50% beginning in April.

Currently, daily intakes ranged for 60 to 70 inmates per day, with most of them occurring between 7 a.m. - 6 p.m. After April 2012, the QMHP staff within the reception area can be reduced and re-directed to the outpatient and residential level of mental health care services as will be described elsewhere in this report. The anticipated infrequent booking that will occur after 6 p.m. will receive suicide risk assessments in a process that will be soon described by policy and procedure that will be consistent with the Stipulated Order of Dismissal.

The Mental Health Housing Units

I visited the pod units for male inmates with mental illness, which had a capacity of 14 single cells in Delta North and 11 single cells in Delta East. All of these cells had been made suicide resistant as per the Stipulated Suicide Prevention Agreement. Each of these units had a cell (i.e., the bubble room) used for constant observation purposes. There was also a television set in a reasonably sized dayroom. Near these housing units were four rooms used for interviewing purposes and a room that used as a workspace for the mental health staff. One deputy was assigned to the control booth, which had a clear view of Delta North and Delta East and another officer essentially served as a housing unit rover for these two pod units.

I also toured the male housing units that had a linear single cell design that ranged from 11 (i.e., the short side) to 14 (i.e., the long side) cells per tier. These housing units did not have a dayroom but did have a long but narrow "hallway" immediately in front of the barred cell fronts with a another narrow celled hallway immediately adjacent. There was a smaller sized version called the "seg block" that consisted of four barred cells. This name was a misnomer because it was not used for segregation purposes.

There was a constant observation unit that was designed as a dormitory, which consisted of four beds in one large room.

There were a total of five cells, in a linear design, for female inmates with mental illness within the Delta housing units. A wall separated a block of three cells from a smaller block of two cells. Alpha unit is a dormitory for women requiring constant observation.

I also toured the keeplock unit in the Gulf East housing unit and briefly talked with most of the inmates in this unit at their cellfront.

Inmates housed in the Delta units are not transferred to ECCF, except under unusual circumstances that generally involve a clinical indication for such a transfer. Inmates who are waiting for a cell in Delta housing units to become available have a "do not transfer to ECCF alert" placed in the ITAG (i.e., the jail management information system).

Medication Administration

Prescribed medications are distributed by the Kinney Pharmaceuticals Services.

Medications are predominantly distributed via a blister pack process.

In general, inmates within the mental health housing units reported minimal continuity of medication issues. Information obtained from mental health staff was consistent with the inmates' reports.

Inmate Interviews

I interviewed most of the inmates in one of the mental health housing units (Delta North) via a group setting and a group of inmates receiving an outpatient level of mental healthcare in Delta Long.

Inmates in the Delta housing units reported seeing either the psychiatrist or psychiatric nurse practitioner on at least a monthly basis in a private office setting. The frequency of one-to-one sessions with their other mental health clinicians (i.e., licensed social workers or licensed mental health counselors) was reported to range from biweekly to monthly. Inmates provided positive descriptions of the general milieu on this unit although they were clear in wanting access to increased programming.

Inmates in the Delta Long housing units were very vocal in wanting better access to mental health services, especially groups and/or individual counseling. Medication continuity issues did not appear to be a significant problem.

Staff Interviews

The line mental health staff at ECHC reported that medication continuity problems were uncommon.

The mental health caseloads assigned to each of the mental health clinicians at ECHC will be about 25 inmates per clinician in the near future.

The mental health staff perceived that that the sick call process was working well. In general, staff reported being able to offer inmates clinical contacts in an office setting with adequate sound privacy.

Erie County Correctional Facility (ECCF)

ECCF was built to house 1,070 convicted prisoners, parole violators, and ECHC overflow inmates. The average daily census was reported to be 780 inmates with an average length of stay for male inmates being 28.51 days and 19.26 days for female inmates. Male inmates in the Yankee housing unit have an average length of stay of 18.76 days.

During the morning of December 8, 2011, I site visited the Erie County Correctional Facility (ECCF). I had the opportunity to meet with the following staff:

1. Superintendent Thomas Diina,
2. Michael R. Ranney, MS, CRC, LMHC,
3. Amanda Leone, LMHC,
4. Bonnie L McLaughlin, MS, LMHC, MS,
5. Penny Drag, LMSW, and
6. Corrine Posluszny, R.N. (Head Nurse).

This medium security correctional facility has a capacity of 884 prisoners with a usual count of 760. Approximately 30% of the prisoners are sentenced inmates in contrast to being pretrial detainees. The keep locked unit has a capacity of 20 inmates with lengths of stay that usually range from 7-10 days. The mental health caseload was reported to range from 240-300 inmates. Caseloads per clinicians ranged from 60 to 90 inmates per clinician.

The current mental health staffing consists of one full-time Forensic Mental Health Specialist II and two part-time Forensic Mental Health Specialists I who work three days per week at the facility (7 to 8 hours per day). Beginning the week of December 11, 2011, the psychiatric coverage will include a Tuesday psychiatrist clinic (8:30 AM-2:30 PM) and a Thursday psychiatric nurse practitioner clinic (8 AM-2:30 PM), which will represent an increase of 4.5 hours of coverage as compared to the present day coverage.

Information obtained from staff indicated that there had been significant problems in receiving healthcare records from ECHC relevant to prisoners being transferred to ECCF although significant improvement during the past several weeks was described. An additional problem was that even when records are obtained, they may be incomplete due to apparent medical record filing issues at ECHC. Several compensatory mechanisms were described by both nursing and mental health staff in the context of this problem, which included nursing staff completing a history and physical examination form, notifying both correctional and health care staff at ECHC regarding the need to send the missing record to ECCF that same day and mental health staff checking electronically whether newly admitted inmates at ECCF were on the mental health caseload at ECHC. None of the above problems have been quantified or audited.

Medication management issues described by mental health staff included verified medications not being prescribed in a timely manner at ECHC and unverified medications being prescribed at ECHC by the nurse practitioners. Periodically medications were reported to be prescribed by a nurse practitioner at ECHC for 365 days. I reviewed an example of such a practice that had also been reported to Dr. Heidelberger by the ECCF mental healthcare staff.

Staff indicated that issues were present regarding adequate office space in order to see mental health caseload inmates in a manner that allowed for adequate sound privacy. This problem was being remedied by construction/renovation of space that should be completed within the next several months.

There been no suicides at ECCF for at least the past year and only one serious suicide attempt during the same period of time. Restraints for mental health purposes have not been used for

over two years. About 1-2 mental health caseload inmates per month are transferred from ECCF to ECHC due to an inability to adequately adjust in the housing units at ECHC. Most of the inmates requiring close observation status will be transferred to ECHC due to cost effectiveness issues.

Mental health staff indicated that individual sessions are generally initiated via the self-referral process due to staff allocation issues. Group therapies are not provided due to similar reasons in addition to physical plant limitations.

The superintendent of this facility is a member of the suicide prevention workgroup (see Stipulated Suicide Prevention Agreement).

The healthcare records of 5 inmates were reviewed (see Appendix IV).

Assessment: Significant mental health system issues were present at ECCF, which included, but were not limited to, the following:

1. Intake screening problems related to not receiving records at ECCF in a timely manner and/or receiving incomplete healthcare records due to apparent medical records filing issues at ECHC. However, this problem has significantly improved in the past month related to new system processes put in place by both medical and custody staffs.
2. I discussed in detail with both the head nurse and mental health staff the types of data that needs to be tracked relevant to the Stipulated Agreements, which should include the following information:
    a. The average number of monthly intakes at ECCF.
    b. The percentages and absolute numbers of monthly intakes at the ECCF who are referred for mental health assessment/treatment.
    c. The average number of mental health referrals at ECCF broken down as follows:
        i. percentage and absolute numbers generated from the ECCF intake process
        ii. percentage and absolute numbers generated from a non-ECCF intake process
        iii. the percentage of ii that resulted from review of the I-Tag system
        iv. the percentage of ii that resulted from de novo (i.e., not currently on the mental health caseload) referrals.
    d. The percentage and absolute numbers on a monthly basis of intakes arriving at ECCF who do not arrive with healthcare records or arrive with healthcare records that do not have the most recent suicide prevention screening guidelines and or healthcare screening form completed. It was my understanding that these SPSG forms are available to clinicians at ECCF electronically via internet access.
    e. For prisoners arriving at ECCF without adequate healthcare records, data

relevant to how long it takes to actually receive the records in addition to data relevant to the nature of the intake screening performed ECCF prior to housing decisions being made.

I explained to staff the rationale for the need for such data, with particular reference to the required staffing analysis as per the Stipulated Order of Dismissal.

The Stipulated Agreements

Appendix V provides a summary of my findings re: the Stipulated Settlement Agreement and Order Concerning Suicide Prevention and Related Mental Health Issues. Appendix VI provides a summary of my findings re: the Stipulated Order of Dismissal.

Executive Summary

The Stipulated Settlement Agreement and Order Concerning Suicide Prevention and Related Mental Health Issues

As compared to Dr. Trestman's July 2011 report, all of the provisions previous assessed to be in substantial compliance have remained in substantial compliance except for A.1.e. (which has to do with privacy issues during healthcare screening.

Five provisions previously assessed to not being compliant are now assessed as being in partial compliance. All the rest of the provisions previously determined to be in partial compliance have remained in partial compliance although many of these provisions are now significantly closer to being in substantial compliance.

One provision C.4.a. remains not ratable at this time.

By agreement of the parties and with approval from Ronald Shansky, M.D., all provisions of this Agreement directly referencing detox services will be monitored in future by Ronald Shansky, M.D. because it will be a more efficient and effective process in the context of his other TCC responsibilities.

In sum, significant progress continues to be made in terms of achieving substantial compliance regarding the provisions of this Stipulated Settlement Agreement. Many of these provisions have been revised in the context of the Stipulated Remedial Order and will be monitored via the Stipulated Remedial Order although specific provisions in the Stipulated Settlement Agreement and Order concerning Suicide Prevention will still apply.

The Stipulated Order of Dismissal

For obvious reasons, the compliance rate with provisions of the Stipulated Order of Dismissal is not close to the compliance rate with the Stipulated Settlement Agreement and Order concerning

Suicide Prevention. Most of the provisions of the Stipulated Order of Dismissal require development of written policies and procedures that reflect the specific requirements in the various provisions of this Stipulated Order. The parties anticipated that development of these policies and procedures would not be completed at the time of the initial monitoring assessment as evidenced by the following provision of Stipulated Order:

> Within 120 days of the Effective Date of this Stipulated Order, Defendant will provide to the TCC and the United States all policies, procedures, and protocols that are contemplated by this Stipulated Order. The United States will provide any comments to the TCC within 90 days thereafter, and the TCC will review the policies, procedures, and protocols for approval. The TCC will approve all policies before they are implemented.

It is my understanding that December 23, 2011 will represent the ending of the 120 days timeframe.

It is encouraging that the mental health services at the Jail have begun implementation of various provisions of this Stipulated Order as resources permit even when policies and procedures have not yet been finalized. For example, five additional mental health specialists have been hired as per the Stipulated Order, which has allowed beginning implementation of the mental health referral process following a positive suicide prevention screening guidelines assessment as required by the Stipulated Order.

In certain other areas the current practice is consistent with the requirements of the Stipulated Order but substantial compliance was not present due to the lack of the required policy and procedure.

Several areas were found to be in substantial compliance which included the hiring of a chief psychiatrist and the provisions relevant the use of chemical spray or other force on prisoners with mental illness.

One of the requirements of the Stipulated Order that is essential to eventually achieving substantial compliance with many of the provisions of this Order has to do with the quality improvement processes. It is very encouraging that DMH has contracted with the Community Connections of New York (CNNY) in addition to hiring Daniel Antonius, Ph.D., because this organization and Dr. Antonius are both skilled in developing an infrastructure for the QI process in addition to actually implementing the QI process.

It is also very encouraging that DMH has continued to develop their relationship with the University of Buffalo's Department of Psychiatry, which has facilitated recruitment of psychiatrists that will eventually contribute to achieving substantial compliance with the Stipulated Order.

The leadership demonstrated by Michael Ranney (Director of Forensic Health Services) along

with the guidance and support from Philip Endress, LCSW (Commissioner, DMH) have been instrumental in the progress demonstrated by the mental health services. In addition, the leadership and corroborative actions demonstrated by First Deputy Superintendent/Compliance Michael Reardon have also been essential in this process.

Attachment A provides a summary of provisions of the Stipulated Settlement Agreement and Order concerning Suicide Prevention and Related Mental Health Issues by compliance rating. A similar attachment will be provided in the future for the Stipulated Order when more provisions have achieved Substantial Compliance.

The Stipulated Order includes the following provisions:

III. SUBSTANTIVE PROVISIONS

Defendant agrees to continue taking all actions necessary to implement the substantive provisions of this Stipulated Order listed below.

A. PROTECTION FROM HARM

1. Sexual Abuse

e. The County will continue to offer all victims of sexual abuse alleged to have occurred in the Facilities access to forensic medical exams performed by Medical staff, whether onsite or at an outside facility, without financial cost. Informed acceptance or refusal of a forensic medical exam must be documented in writing.

f. The County will ensure appropriate counseling services are made available to victims of sexual abuse, provided by a qualified staff member or a victim advocate from a community-based organization that provides services to sexual abuse victims.

l. The County will ensure that all full- and part-time qualified health and qualified mental health professionals who work regularly in ECHC and ECCF and have contact with prisoners have been trained in:

i. How to detect and assess signs of sexual abuse;
ii. How to preserve physical evidence of sexual abuse;
iii. How to respond effectively and professionally to victims of sexual abuse;
iv. How and to whom to report allegations or suspicions of sexual abuse.

Both parties, at the request of Mr. Manuel Romero, requested assistance from the medical and mental health TCC's in monitoring the above provisions. I have agreed to review 1.f. I will ask Dr. Shansky to review 1.e. and the monitor whether the training provisions of provision l have occurred.

I received comments from the DOJ re: my December draft report. No comments were received from Erie County. The DOJ suggested that the final report provides additional detail regarding thresholds for substantial compliance to be achieved and indicators that will be reviewed. The indicators will essentially be driven by the policies and procedures that are currently being developed to implement the various provisions of the Stipulated Order. In general, a compliance rate of 90% will be required to achieve substantial compliance.

My next site visit will be from June 4-7, 2012. Appendix VII provides a summary of my requests for pre-site information.

Please do not hesitate to contact me if I can answer any further questions.*

Sincerely,

Jeffrey L Metzner, M.D.
Clinical Professor of Psychiatry
University of Colorado School of Medicine

*This report was transcribed via the use of voice software, which may explain any typographical errors still present.